2009 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

In 2008, the Department of Health Care Services (DHCS) held contracts with 21 full-scope health plans and four specialty plans to provide health care services to approximately 3.4 million members enrolled in the Medi-Cal Managed Care (MCMC) Program.

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

In 2008, the EAS consisted of 12 performance measures with 22 distinct rates providing information on access to care for women, adolescents, and children; ambulatory care services; screening for diseases such as breast and cervical cancer; care provided to members with chronic diseases such as diabetes and asthma; and appropriate treatment for other conditions such as upper respiratory infection (URI) in children and acute bronchitis in adults.

The DHCS based all selected performance measures on the Healthcare Effectiveness Data and Information Set (HEDIS®[1]) developed by the National Committee for Quality Assurance (NCQA). This 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 health plans' Medicare, Medicaid, and commercial lines of business.

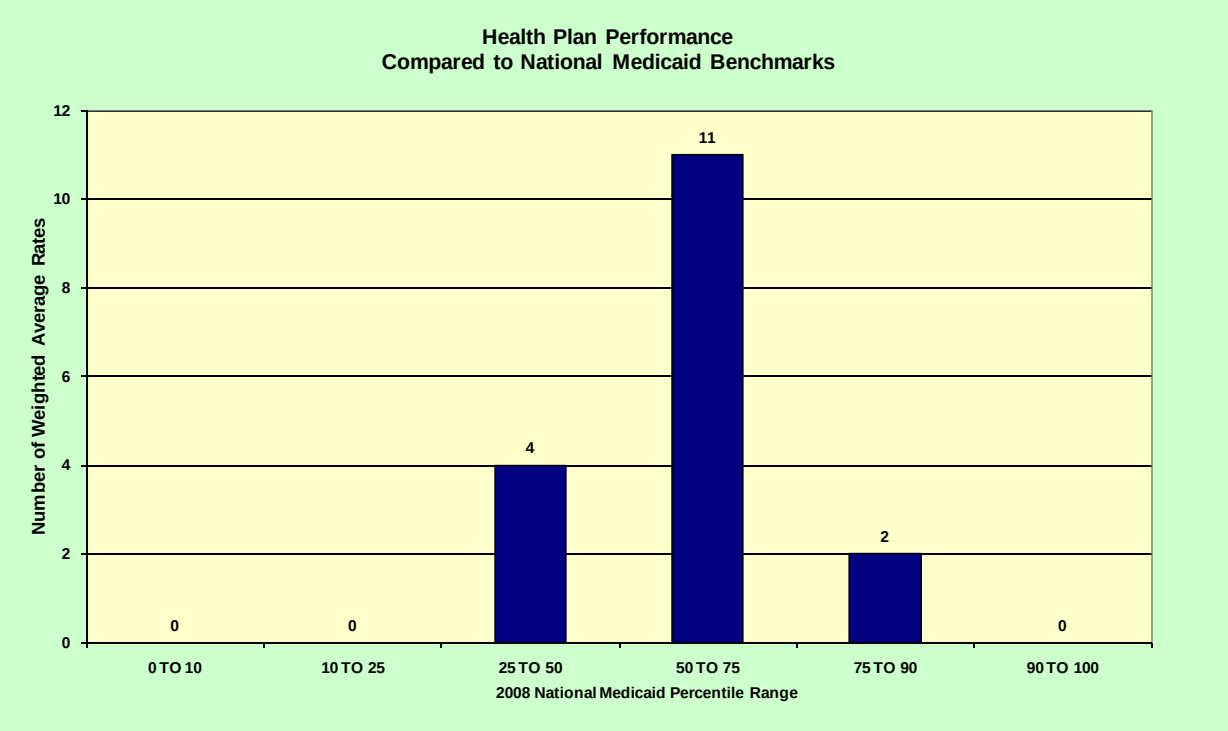
As part of the EAS, the DHCS requires plans to undergo a HEDIS Compliance Audit™ conducted by an external quality review organization (EQRO). The EQRO assesses plans' information systems (IS) capabilities and compliance with HEDIS specifications to ensure standardized reporting of performance measure results. The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), to perform these on-site compliance audits in 2009, analyze MCMC HEDIS rates objectively, and evaluate each plan's current performance level relative to local and national thresholds and benchmarks.

This report presents Medi-Cal Managed Care HEDIS 2009 results for the 2008 measurement period of January 1, 2008, through December 31, 2008.

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

Key Findings

The MCMC Program as a whole demonstrated average performance for most measures, with some strengths noted, as well as areas that need improvement. Compared to 2008 national Medicaid benchmarks, the MCMC Program's performance was consistent with the 50th percentile, as evidenced by 11 weighted averages falling into this category. The program performed above the 75th percentile for the *Childhood Immunization Status—Combination 3* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures. The program performed between the 25th percentile and 50th percentile on four measures: *Prenatal and Postpartum Care — Timeliness of Prenatal Care*, *Prenatal and Postpartum Care—Postpartum Care*, *Use of Appropriate Medications for People With Asthma,* and *Well-Child Visits in the First 15 Months of Life (Six or More Visits).*



The MCMC Program performed better on nine performance measures and worse on eight performance measures in 2009 compared to 2008. HSAG did not compare performance on the *Ambulatory Care* measures in 2008 and 2009 because they are utilization indicators. Higher or lower rates do not necessarily indicate better or worse performance for these measures. In addition, significant methodology changes to the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control* measure did not allow a direct comparison of performance in 2008 and 2009.

Of the MCMC weighted average changes between 2008 and 2009, only the *Adolescent Well-Care Visits* and *Childhood Immunization Status—Combination 3* measures showed statistically significant improvement between 2008 and 2009. No decreases in performance were statistically significant.

High and Low Performance

Four full-scope plans demonstrated high performance across the EAS, exceeding six or more of the DHCS's established high performance levels (HPLs), which represent the national Medicaid 90th percentile. Kaiser Permanente (North)—Sacramento County and San Francisco Health Plan—San Francisco County both exceeded the HPL on 11 measures while Kaiser Permanente (South)—San Diego County exceeded the HPL on eight performance measures, followed by CenCal Health—Santa Barbara County , which had six measures that exceeded the HPL. The remaining plans had zero to three measures that performed above the HPL.

Four plans showed the greatest opportunity for improvement, with seven or more performance measures below the DHCS-established minimum performance level (MPL), which represents the national Medicaid 25th percentile. The Anthem Blue Cross plans for Alameda and Contra Costa counties were below the MPL for 10 measures, while Anthem Blue Cross—Sacramento County and Molina Healthcare—Riverside and San Bernardino counties had rates below the MPL for each of seven performance indicators. All other plans had zero to five measures that performed below the MPL.

In assessing plans' strengths across the performance measures, HSAG noted that the *Appropriate Treatment for Children With Upper Respiratory Infection* measure had the highest number of plans (eight) scoring above the HPL. In addition, seven plans performed above the HPL for *Prenatal and Postpartum Care—Postpartum Care* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

HSAG noted that the *Breast Cancer Screening* measure showed the greatest opportunity for improvement, with nine plans scoring below the DHCS-established MPL of 44.4 percent. In addition, six plans ranked below the MPL with respect to *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing,* and seven plans performed below the MPL for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent).* Appendix C provides a summary of plan performance across measures relative to the DHCS-established MPLs and HPLs.

Model Type Performance

The County-Operated Health System (COHS) model type outperformed the Geographic Managed Care (GMC) and Two-Plan model types on 14 of 18 performance measures. The Two-Plan model performed best on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis, Cervical Cancer Screening, and Prenatal and Postpartum Care—Timeliness of Prenatal Care* measures while the GMC model type outperformed the others on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure.

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

Performance Measure Compliance Audit Key Findings

HSAG conducted performance measure validation of 24 MCMC plans. All plans audited were compliant with the required information systems standards. Overall, plans demonstrated the ability to process, receive, and enter medical and service data efficiently, accurately, timely, and completely.

Several plans experienced challenges with their medical record review vendors that resulted in some plans providing more oversight and resources than planned or anticipated.

Few plans had mechanisms in place for tracking and trending the volume of vendor data. This information is useful to plans in identifying potential data issues, including missing data, and allows plans to address these issues proactively.

Conclusions and Recommendations

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

The DHCS has implemented a variety of mechanisms to support the improvement efforts of plans. The auto-assignment program offers an increased incentive for plans in the GMC and Two-Plan model types to perform well by rewarding higher-performing plans with increased default membership. In addition, DHCS and plan participation in statewide quality improvement projects (QIPs) seems to further improve performance measure rates. Finally, the DHCS began evaluation of its EAS and auto-assignment program measures annually and intends to rotate out measures that show consistent, high performance among plans. The DHCS will then identify and select new measures as opportunities for improvement.

Based on the review of the 2009 HEDIS results, HSAG provides the following recommendations for continued improvement to the DHCS and the plans:

- Plans need to consider selecting low-performing areas for QIP topics rather than selecting areas of consistent or high performance.

- The DHCS needs to reevaluate the effectiveness of its required HEDIS improvement plans as several plans showed a pattern of poor performance over consecutive years.
- Plans need to develop a mechanism to track vendor data volume as a means to identify potential missing data or other data issues.
- The DHCS may consider selecting one of its low-performing EAS measures for its next statewide collaborative QIP since this approach has been successful with other measures.
- Plans with best practices should share their success in improving performance measures through targeted interventions with other plans and state Medicaid programs.

Medi-Cal Managed Care Program Overview

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

During 2008, the DHCS contracted with 21 full-scope plans and four specialty plans, operating throughout California in 25 of California's 58 counties, to provide health care services to approximately 3.4 million members enrolled in managed care plans.

Medi-Cal Managed Care Program Delivery System

The DHCS operates the MCMC Program through a service delivery system that encompasses three different plan model types for its full-scope services: the COHS, GMC, and Two-Plan model types. The DHCS monitors plan performance across model types. Table 2.1 on page 8 shows participating MCMC plans by model type.

County-Organized Health System

In a COHS model type, the DHCS initiates contracts with county organized and operated plans to provide managed care services to members with designated mandatory aid codes. In a COHS plan, members can choose from a wide network of managed care providers. These members do not have the option of enrolling in fee-for-service Medi-Cal unless authorized by the plan. The DHCS currently has contracts with five COHS plans that operate in nine counties.

Geographic Managed Care

The GMC model type allows enrollees to choose from several commercially-operated plans within a specified geographic area. Similar to the COHS model type, the DHCS requires enrollment in a managed care plan for designated aid codes, except for seniors and persons with disabilities who are eligible for Medi-Cal benefits under the Supplemental Security Income (SSI) Program and have the option to enroll in either the managed care program or fee-for-service system. The GMC model type currently operates in San Diego and Sacramento counties.

Two-Plan

In a Two-Plan model type, the DHCS contracts with two managed care plans in each county to provide medical services to members. Most counties offer a locally-operated local initiative (LI) plan and a nongovernmental commercial health plan. Like the GMC model type, the DHCS requires enrollment in a managed care plan for designated aid codes with the same exception for seniors and persons with disabilities eligible for Medi-Cal benefits under the SSI program, who can choose between the managed care program and fee-for-service system. The MCMC recipients may enroll in either the LI plan or the commercial plan. Currently, the Two-Plan model operates in 12 counties.

Specialty Plans

In addition to the full-scope plans, the DHCS, in some instances, contracts with plans to provide specialty care services. During the measurement period, the DHCS held contracts with four specialty plans operating in a total of six counties. The DHCS requires specialty plans to report on two approved performance measures.

Table 2.1—Medi-Cal Managed Care Program Plans by Model Type

Model Type		Plan Name	County
County-Organized Health System		CalOptima	Orange
		CenCal Health	Santa Barbara, San Luis Obispo
		Central CA Alliance for Health*	Monterey, Santa Cruz
		Health Plan of San Mateo	San Mateo
		Partnership Health Plan	Napa, Solano, Yolo
Geographic Managed Care		Anthem Blue Cross	Sacramento
		Care 1st	San Diego
		Community Health Group	San Diego
		Health Net	Sacramento
		Health Net	San Diego
		Kaiser Permanente—North	Sacramento
		Kaiser Permanente—South	San Diego
		Molina Healthcare	Sacramento
		Molina Healthcare	San Diego
		Western Health Advantage	Sacramento
Two-Plan	**Commercial**	Anthem Blue Cross	Alameda
		Anthem Blue Cross	Contra Costa
		Anthem Blue Cross	Fresno
		Anthem Blue Cross	San Francisco
		Anthem Blue Cross	San Joaquin
		Anthem Blue Cross	Santa Clara
		Health Net	Fresno
		Health Net	Kern
		Health Net	Los Angeles
		Health Net	Stanislaus
		Health Net	Tulare
		Molina Healthcare	Riverside, San Bernardino
	Local Initiative	Alameda Alliance for Health	Alameda
		Anthem Blue Cross	Stanislaus
		Anthem Blue Cross	Tulare
		Contra Costa Health Plan	Contra Costa
		Health Plan of San Joaquin	San Joaquin
		Inland Empire Health Plan	Riverside, San Bernardino
		Kern Family Health Care	Kern
		LA Care Health Plan	Los Angeles
		San Francisco Health Plan	San Francisco
		Santa Clara Family Health	Santa Clara
Specialty Plan		AHF Healthcare Centers	Los Angeles
		Family Mosaic Project	San Francisco
		Kaiser PHP	Marin, Sonoma
		SCAN Health Plan	Los Angeles, Riverside, San Bernardino

* Central Coast Alliance for Health's name became Central California Alliance for Health July 1, 2008.

How the DHCS Uses Performance Measures

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

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

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

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

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

The DHCS also gives annual quality awards to plans in recognition of their accomplishments. The criteria for these awards are based largely on plans' HEDIS results for exceptional performance or marked improvement.

Minimum Performance Levels and High Performance Levels

The DHCS establishes both MPLs and HPLs for each required performance measure annually. Using NCQA's *HEDIS 2008 Audit Means, Percentiles and Ratios*, the DHCS currently bases its MPLs on the Medicaid national 25th percentile. Plans have a contract requirement to perform at or above the established MPL. Plans that have rates below the MPL must submit an improvement plan to the DHCS outlining the steps they will take to improve care. The DHCS established HPLs based on the national Medicaid 90th percentile. Plan performance in relation to the MPL and HPL for each measure becomes public record with the release of this report.

Pay-for-Performance Program

Currently, six performance measures are part of the DHCS's auto-assignment program, which awards Two-Plan and GMC model plans that score high on these measures with increased default enrollment. The auto-assignment program encourages plans to improve and/or maintain quality of care and services provided to their members.

Medi-Cal Managed Care Program's 2009 HEDIS Measures

The DHCS's 2009 EAS for full-scope plans, which uses 2008 measurement year data, includes the following measures:

- *Adolescent Well-Care Visits*
- *Ambulatory Care*
  - *Ambulatory Surgery/Procedures*
  - *Emergency Department (ED) Visits*
  - *Observation Room Stays*
  - *Outpatient Visits*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care*
  - *Eye Exam (Retinal) Performed*
  - *Hemoglobin A1c (HbA1c) Testing*
  - *HbA1c Poor Control (>9.0 Percent)*
  - *HbA1c Control (<7.0 Percent)*
  - *LDL-C Screening*
  - *LDL-C Control*
  - *Medical Attention for Nephropathy*
- *Prenatal and Postpartum Care*
  - *Timeliness of Prenatal Care*
  - *Postpartum Care*
- *Use of Appropriate Medications for People With Asthma*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

About HEDIS

HEDIS, developed by NCQA, is a standardized set of 74 performance measures used to provide health care purchasers, consumers, and others with a reliable comparison among health plans. HEDIS data are often used to produce health plan "report cards," analyze quality improvement activities, and benchmark performance. NCQA classifies the broad range of HEDIS measures across eight domains of care:

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

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

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

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

How HEDIS Results are Calculated and Displayed

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

Methodology

To assist plans in standardized reporting, NCQA develops and makes available technical specifications that provide information on how to collect data for each measure, with general guidelines for sampling and calculating rates. The DHCS's EAS requirements for 2009 indicate that plans are responsible for adhering to the *HEDIS 2009 Technical Specifications*.

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

The HEDIS process begins well in advance of plans reporting their rates. Plans calculate their 2009 HEDIS rates with measurement data from January 1, 2008, to December 31, 2008. Performance measure calculation and reporting typically involves three phases: Pre-On-site, On-site, and Post-On-site.[2]

Pre-On-site Activity (October to December)

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

On-site Activity (January to April)

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

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

Post-On-site Activity (May to October)

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

Data Collection Methodology

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

Administrative Method

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

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

- *Ambulatory Care*
- *Adults' Access to Preventive/Ambulatory Health Services**
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Appropriate Testing for Children With Pharyngitis**
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Breast Cancer Screening*
- *Glaucoma Screening in Older Adults**
- *Persistence of Beta-Blocker Treatment After a Heart Attack**
- *Use of Appropriate Medications for People With Asthma*

* A specialty plan measure

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

Hybrid Method

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

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

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

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

- *Adolescent Well-Care Visits*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Colorectal Cancer Screening**
- *Comprehensive Diabetes Care*
- *Prenatal and Postpartum Care*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

* A specialty plan measure

Plans that have complete and robust administrative data may choose to report measures using only the administrative method and avoid labor-intensive medical record review; however, currently only two of the Medi-Cal Managed Care (MCMC) contracted plans report rates in this manner, Kaiser Permanente—North (Sacramento County) and Kaiser Permanente—South (San Diego County). The Kaiser plans have information systems capabilities, primarily due to their closed-system model and electronic medical records, that support administrative-only reporting because medical record review does not generally yield additional data beyond what the plan had already captured administratively.

HEDIS Aggregate Report Data Displays

This report displays 2009 HEDIS results relative to both local and national performance thresholds and benchmarks to compare the quality of services provided to MCMC members. A comparison of performance gives the DHCS and plans the opportunity to identify opportunities to improve care.

National benchmarks displayed in this report include the national Medicaid average and the national commercial average as reported by NCQA. Healthy People 2010 goals provide another source of national benchmarks for comparison within this report, as available.[3] Local benchmarks include prior-year MCMC weighted averages and California Healthy Families Program (HFP) weighted averages.[4]

Plans' submission of HEDIS data provides rates calculated to the sixth decimal place. Results in this report are rounded to the first decimal place to be consistent with the display of comparative local and national benchmarks. Some rounded rates may appear the same; however, the more precise rates are not identical. In these instances, the graphs display the correct hierarchy of scores.

Medi-Cal Managed Care Program Weighted Averages

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

HSAG computed the 2009 MCMC weighted average for each measure using plan-reported rates and weighted these by each plan's reported eligible population size for the measure. This is a better estimate of care for all MCMC enrollees than a straight average of MCMC plans' performance.

Significance Testing

In this report HSAG analyzes differences between the 2008 and 2009 MCMC weighted averages, using 2008 and 2009 rates and a *t* test to determine if the change was statistically significant. The *t* test evaluates the differences between the mean values of two groups relative to the variability of the distribution in the scores. HSAG uses a z test to determine plan-specific differences between

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

[4] California Healthy Families Program, California's State Children's Health Insurance Program (SCHIP), provides health, vision, and dental coverage to children who do not have insurance and do not qualify for Medi-Cal.

2008 and 2009 rates to assess if a change is statistically significant. The *t* values and *z* values generated are 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 5 times out of 100 we may find a statistically significant difference between the mean values even if none actually existed (i.e., it happened by chance). All comparisons between the 2008 and 2009 MCMC weighted averages reported as statistically significant in this report are significant at the 0.05 risk level.

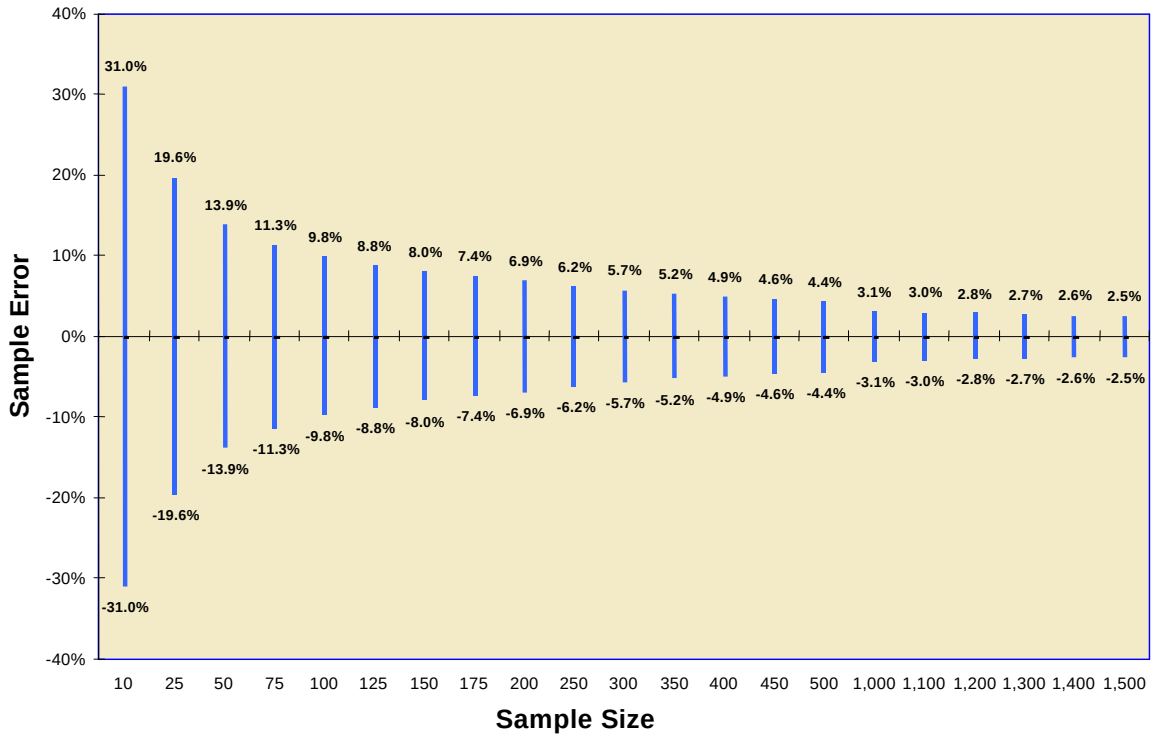
Understanding Sampling Error and Effect Size

The 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 do medical record review for the entire eligible population for a given measure. Measures collected using the HEDIS hybrid method include only a sample from the population, and statistical techniques are used to maximize the probability that the sample results reflect the experience of the entire eligible population.

To generalize results to the entire 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 for selecting members of 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 *Prenatal and Postpartum Care*).

Figure 3.1 shows that if a measure includes 411 health plan members, the margin of error is approximately ± 5.0 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 number 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 2009 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 plans performing overall?**

Results Accuracy

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

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

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

Comparing Medi-Cal Managed Care Program Rates to National Percentiles

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

- 2008 National Medicaid Average—The most current available mean rate of all Medicaid plans nationwide that reported rates to NCQA in 2008
- 2008 National Commercial Average—The most current available mean rate of all commercial plans nationwide that reported rates to NCQA in 2008
- 2008 California Healthy Families Average—The program's 2008 weighted average rates
- Healthy People 2010—The available, established, and relevant goals similar to the MCMC Program's EAS

Medi-Cal Managed Care Plans' Overall Performance

The DHCS establishes performance thresholds annually for minimum performance and high performance. This report displays each plan's rate relative to the established MPL and HPL for each measure, with the highest threshold or rate at the top of the chart, continuing in descending order to the lowest threshold or rate. Using NCQA's *HEDIS 2008 Audit Means, Percentiles and Ratios,* the DHCS established its MPLs and HPLs for its HEDIS 2009 EAS. The DHCS based the MPLs on the 2008 Medicaid national 25th percentile and its HPLs on the 2008 Medicaid national 90th percentile, which represent the most recent data available from NCQA. Appendix A includes all the HEDIS 2008 national Medicaid percentiles.

In prior years the DHCS used the 25th and 90th Medicaid percentiles from NCQA's *Quality Compass* for its MPLs and HPLs. While the percentiles are nearly identical for these two sources, the DHCS opted to use the *HEDIS 2008 Audit Means, Percentile, and Ratios* since NCQA makes this data publicly available.

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

There is one measure for which this differs—i.e., 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:

- *Comprehensive Diabetes Care—HbA1c Poor Control* (lower rates of poor control indicate better care)

For two specialty plans, two of the selected performance measures, *Colorectal Cancer Screening* and *Glaucoma Screening in Older Adults*, do not have established national percentiles for the Medicaid population. For these measures HSAG and the DHCS use either the established Medicare or the commercial 25th and 90th percentiles for comparison, depending on the unique characteristics of each specialty plan's population.

Finally, the DHCS eliminated application of an MPL/HPL for *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<7.0 percent)* due to the significant methodology changes between the 2008 and 2009 technical specifications.

This report displays *Ambulatory Care* measure results separately in Section 6. This measure reports plan utilization for outpatient visits, emergency department visits, ambulatory surgery procedures, and observation room stays. Utilization information can help plans identify patterns of under- and overutilization of services; however, high and low rates do not always indicate better or worse performance. For this reason, the DHCS does not establish MPLs and HPLs, and HSAG does not provide comparative analysis.

Performance Trend Analysis

In Appendix B, the column, "2008–2009 Health Plan Trend," shows, by measure, a comparison between the HEDIS 2008 results and the 2009 results for each plan. HSAG used a z test for two proportions to calculate the statistical significance between plan rates in 2008 and 2009. The table shows trends graphically using the key below:

- ↑ Denotes a statistically significant improvement in performance
- ⇦⇨ Denotes no statistically significant change in performance
- ↓ Denotes a statistically significant decline in performance

Health Plan Name Key

The following table displays a listing of plan and county names used throughout the report.

	Plan Name	County[1]
	AHF Healthcare Centers*	Los Angeles
	Alameda Alliance for Health	Alameda
	Anthem Blue Cross	Alameda
	Anthem Blue Cross	Contra Costa
	Anthem Blue Cross	Fresno
	Anthem Blue Cross	Sacramento
	Anthem Blue Cross	San Francisco
	Anthem Blue Cross	San Joaquin
	Anthem Blue Cross	Santa Clara
	Anthem Blue Cross	Stanislaus

Plan Name	County[1]
Anthem Blue Cross	Tulare
CalOptima	Orange
Care 1st	San Diego
CenCal Health	San Luis Obispo
CenCal Health	Santa Barbara
Central CA Alliance for Health[2]	Mnty./StCz.
Community Health Group	San Diego
Contra Costa Health Plan	Contra Costa
Family Mosaic Project*	San Francisco
Health Net	Fresno
Health Net	Kern
Health Net	Los Angeles
Health Net	Sacramento
Health Net	San Diego
Health Net	Stanislaus
Health Net	Tulare
Health Plan of San Joaquin	San Joaquin
Health Plan of San Mateo	San Mateo
Inland Empire Health Plan	R/SB
Kaiser Permanente—North	Sacramento
Kaiser Permanente—South	San Diego
Kaiser PHP*	Marin/Sonoma
Kern Family Health Care	Kern
LA Care Health Plan	Los Angeles
Molina Healthcare	R/SB
Molina Healthcare	Sacramento
Molina Healthcare	San Diego
Partnership Health Plan[3]	Np/Sol/Yo
San Francisco Health Plan	San Francisco
Santa Clara Family Health	Santa Clara
SCAN Health Plan*	Los Angeles, R/SB
Western Health Advantage	Sacramento

1. Multiple county abbreviations include: Mnty./StCz. for Monterey/Santa Cruz, Np/Sol/Yo for Napa/Solano/Yolo, and R/SB for Riverside/San Bernardino.
2. Central Coast Alliance for Health's name became Central California Alliance for Health on July 1, 2008.
3. Partnership Health Plan expanded into Sonoma County on July 1, 2009; however, Sonoma County data will not be included in the plan's 2009 HEDIS rates.

* Specialty plan

HEDIS Performance Measures Name Key

The table below provides abbreviations used throughout this report.

	Abbreviation	Full Name
	AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
	AMB-ED	*Ambulatory Care (AMB)—ED Visits (per 1,000 Member Months)*
	AMB-OV	*AMB—Outpatient Visits (per 1,000 Member Months)*
	AMB-OR	*AMB—Observation Room Stays (per 1,000 Member Months)*
	AMB-SP	*AMB—Ambulatory Surgery/Procedures (per 1,000 Member Months)*
	ASM	*Use of Appropriate Medications for People With Asthma*
	AWC	*Adolescent Well-Care Visits*
	BCS	*Breast Cancer Screening*
	CCS	*Cervical Cancer Screening*
	CDC-E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
	CDC-H7	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)*
	CDC-H9	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
	CDC-HT	*Comprehensive Diabetes Care—HbA1c Testing*
	CDC-LC	*Comprehensive Diabetes Care—LDL-C Control*
	CDC-LS	*Comprehensive Diabetes Care—LDL-C Screening*
	CDC-N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
	CIS-3	*Childhood Immunization Status—Combination 3*
	PPC-Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
	PPC-Pst	*Prenatal and Postpartum Care—Postpartum Care*
	URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
	W15	*Well-Child Visits in the First 15 Months of Life (Six or More Visits)*
	W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

About Performance Measure Validation

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

To comply with this requirement, the DHCS contracted with HSAG to conduct validation of the selected EAS performance measures. Because all the selected EAS measures are also HEDIS measures, HSAG conducted audits in accordance with the 2009 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that plans must meet, including the criteria for any manual processes used to report HEDIS information. When a plan did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. Plans not fully compliant with all of the IS standards may still report all measures as long as the final reported rate is not significantly affected.

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 IS standard is not covered under the scope of the Medi-Cal Managed Care Program audit)
- IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

Audit Designations

Through the audit process HSAG assigns an NCQA-defined audit finding for each measure reported by a plan. Measures receive one of four predefined audit findings: *Report*, *Not Applicable*, *Not Report*, and *No Benefit*.

An audit finding of *Report* indicates that the plan complied with all HEDIS specifications to produce an unbiased, reportable rate or rates that can be released for public reporting. Although a plan may have complied with all applicable specifications, HSAG will assign a *Not Applicable* audit finding if the plan's denominator is too small to report (less than 30). An audit finding of *Not Report* indicates that the rate should not be publicly reported because the measure deviated from HEDIS specifications enough to bias the reported rate significantly or that the plan chose not to report the measure. A *No Benefit* audit finding indicates that the plan did not offer the benefit required by the measure.

HEDIS Reporting Capabilities

Key Findings

Of the 25 DHCS-contracted plans, 24 underwent performance measure validation. Either HSAG's NCQA-certified compliance auditors or HSAG's subcontracted NCQA-certified compliance auditors performed the plan audits for the 2009 reporting year. Family Mosaic Project, a specialty plan, did not have established performance measures in place for data reporting during the 2008 measurement year.

Nineteen of the 24 audited plans used an NCQA-certified software vendor to produce rates. All of the software vendors used by the plans achieved full certification status for the reported HEDIS measures. Five plans produced internally developed source code and programming logic to produce the HEDIS measures that HSAG reviewed and approved.

Strengths

All plans were compliant with the required IS standards. Plans demonstrated that they used industry standard codes and captured primary and secondary codes. For nonstandard codes, plans appropriately mapped these to industry standard codes. Overall processes to receive and enter medical and service data were efficient, accurate, timely, and complete.

Despite some challenges with medical record abstraction vendors, the plans implemented processes for reliable and accurate data abstraction. HSAG noted that many plans have knowledgeable and skilled HEDIS project staff dedicated to accurate HEDIS reporting.

Plans were compliant with capturing accurate, complete, and timely membership data as well as practitioner data.

In addition, all of the plans complied with HEDIS reporting software and physical control procedures to effectively manage and ensure the integrity of the HEDIS data.

HSAG noted many best practices among plans to improve data accuracy, data completeness, or HEDIS rates. They include the following:

- A financial or provider incentive program to encourage providers to gather and submit timely encounter data
- Use of electronic health records to increase the capture of administrative data
- Alignment of pay-for-performance and quality initiatives with HEDIS measures
- Use of regional immunization registry data and other supplemental databases

Challenges

Some plans experienced challenges with contracted vendors initiating timely and accurate medical record abstraction, which resulted in greater oversight at the plan level. In addition, plans transitioning to a new medical record abstraction vendor or medical record abstraction tools had to make modifications to their timelines and processes. Not all plans had an ongoing over-read process throughout the medical record abstraction period, which could have resulted in uncorrected abstraction errors.

Several plans had a significant claims backlog. In some cases this was due to a transition between claims vendors or large-scale systems conversions. Plans resolved the backlogs by the time they finalized their HEDIS measures for reporting.

Many plans received a *Not Report* for their *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<7.0 Percent)* measure, which had significant revisions to the measure specifications from the previous year. Plans had difficulty achieving the required sample size due to a high number of unexpected member exclusions. For many plans, the added cost to re-sample and abstract medical records to report a valid rate was a barrier, and some plans opted to receive a *Not Report*.

One plan was not able to report its eye exam rate under the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure due to material bias.

An opportunity exists for some plans to either decrease the amount of manual processes or implement formal audit processes to adequately monitor data entry accuracy, the receipt of claims and encounter data, and manual crosswalks.

Most plans still rely on medical record review to obtain lab values instead of obtaining these data electronically, which increases the resource burden on plans and providers.

Plans that obtain data from vendors such as vision, pharmacy, or lab vendors one time per year or at the end of the year may be missing some data not accounted for due to claims lag. In addition, not all plans have adequate tracking and trending of the volume of vendor data to identify potential data issues or missing data concurrently and are not able to address these issues proactively.

Recommendations

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

- Implement a formal claims audit program that incorporates validation of manual data entry randomly across all examiners and claims types
- Identify ways to improve the control of paper batches of claims and encounter data from the point of receipt through processing to decrease the potential for lost claims
- Explore methods for identifying whether data from clearinghouses are accurate and complete, including the data exchange between vendors/provider groups and clearinghouses
- Explore mechanisms to collect lab values administratively to decrease medical record chart abstraction and pursuit
- Implement a medical record over-read process throughout the abstraction phase
- Implement a process for vendor data refresh to account for claims lag
- Implement a formal process for tracking and trending the volume of vendor data (vision, lab, pharmacy) to identify expected volumes and address any data issues or possible losses as they occur
- Explore the ability to access regional immunization registry data

Adolescent Well-Care Visits

Measure Definition

This measure reports the percentage of adolescents 12 to 21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician or gynecologist during the measurement year.

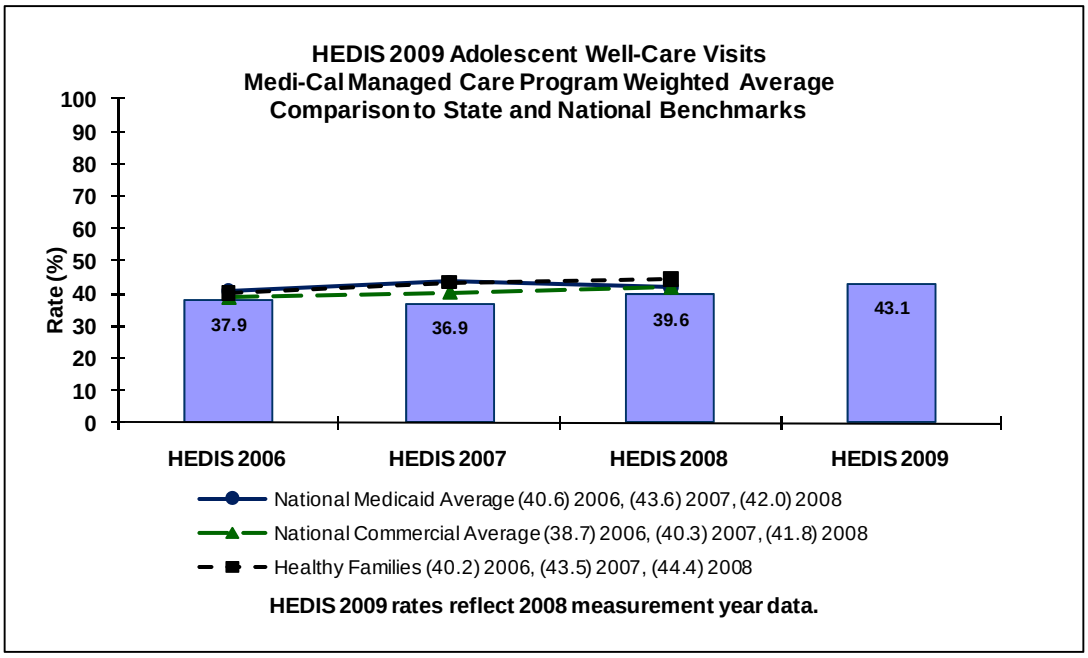
Importance

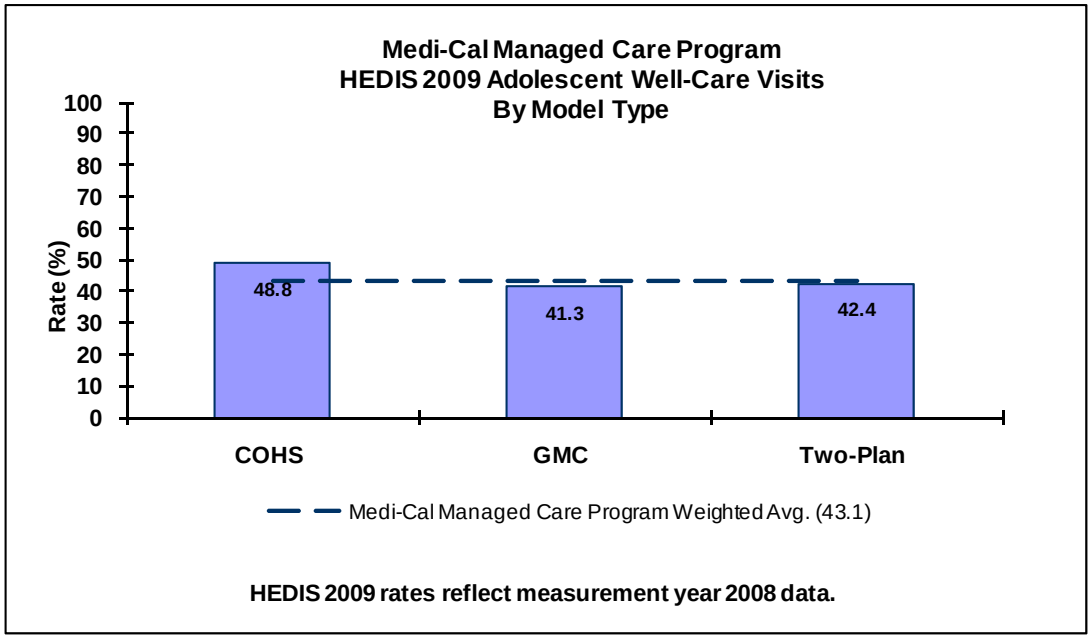
The American Medical Association's (AMA's) Guidelines for Adolescent Preventive Services recommend that all adolescents 11 to 21 years of age have an annual preventive services visit that focuses on both the biomedical and psychosocial aspects of health.[5]

Because sexually transmitted diseases, substance abuse, pregnancy, and antisocial behavior are important causes of physical, emotional, and social problems among the adolescent age group, an annual preventive services visit provides an opportunity for provider assessment and intervention.

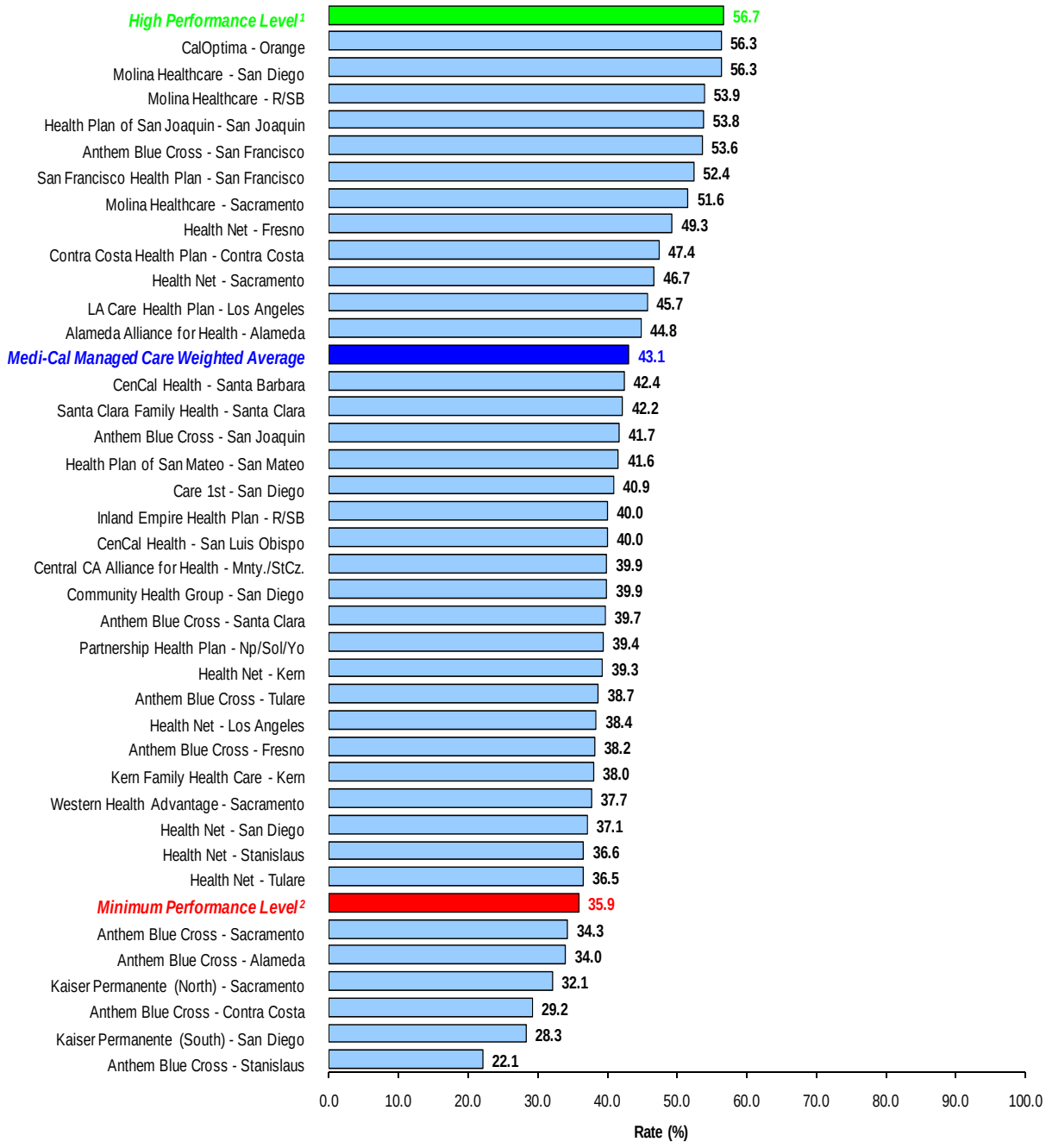
[5] American Medical Association. Guidelines for Adolescent Preventive Services (GAPS). Available at: http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf. Accessed August 31, 2009.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Adolescent Well-Care Visits



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The Medi-Cal Managed Care (MCMC) Program's weighted average for *Adolescent Well-Care Visits* has gradually increased over time, with statistically significant improvement between 2008 and 2009. The program's 2009 weighted average was above both the 2008 national Medicaid and commercial averages. This is the first year that the program performed above these national benchmarks.

In January 2004, the DHCS and the MCMC plans initiated a statewide collaborative quality improvement project (QIP) to improve the screening, counseling, and health education that adolescents receive from PCPs. The DHCS and the plans developed the collaborative in response to low 2004 HEDIS *Adolescent Well-Care Visits* rates. The QIP may have contributed to plans' ongoing success with performance improvement in this area. Several successful interventions have allowed plans to sustain improvement over several years, increasing well-child and member visits. The use of a mandated topic for the collaborative QIP proved effective in improving the overall statewide rates for adolescent well-care visits, particularly because all contracted plans participated.[6]

In addition, the DHCS implemented its auto-assignment program in December 2005, which included *Adolescent Well-Care Visits* as one of the measures used to reward higher-scoring Two-Plan and GMC model plans with increased default enrollment. While this incentive was in place for GMC and Two-Plan model plans in 2009, the COHS model type outperformed all model types with an average above the MCMC weighted average.

High and Low Performers

Despite the MCMC Program's overall weighted average increase, no plan achieved the HPL. Both of Kaiser Permanente's counties and four of Anthem Blue Cross' nine counties performed below the DHCS-established MPL in 2009. Moreover, of the six plans that performed below the MPL, five had rates below the MPL for this measure in 2008.

Plan performance since 2006 has demonstrated overall improvement. In 2006, 24 plans fell below the established MPL. In 2007, that number fell to 14, followed by another reduction in 2008 to 9 plans. In 2009, only 6 plans fell below the MPL.

Best Practices

To explore potential best practices, HSAG evaluated and categorized interventions that appeared to be more successful in bringing about improvement. In addition to the demonstrated success of collaborative QIPs in improving adolescent well-care visit rates, HSAG noted that successful

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

QIPs had interventions targeting specific barriers in conjunction with a provider-related intervention. Provider interventions included provider-specific feedback on well-care visit rates and encounter/claims data review for missed opportunities such as performing well-care assessments during sick visits. Electronic tracking tools and provider prompts are associated with greater provider satisfaction rates as well as increased well-care visit rates.

Appropriate Treatment for Children With Upper Respiratory Infection

Measure Definition

This measure reports the percentage of members 3 months through 18 years of age who were diagnosed with a URI and who were not dispensed an antibiotic prescription.

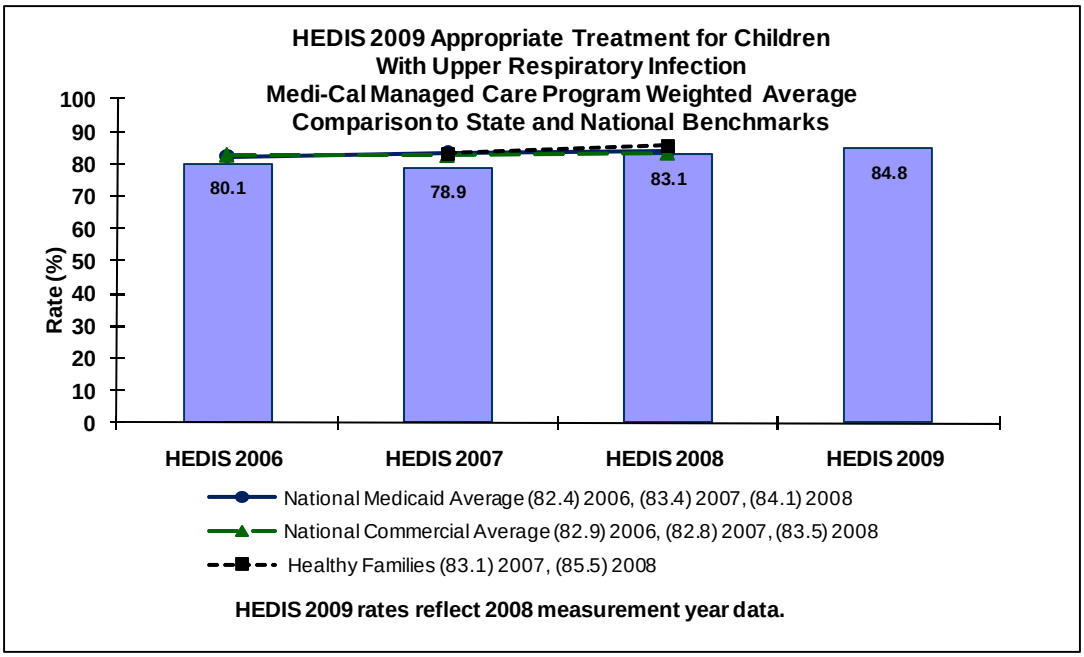
Importance

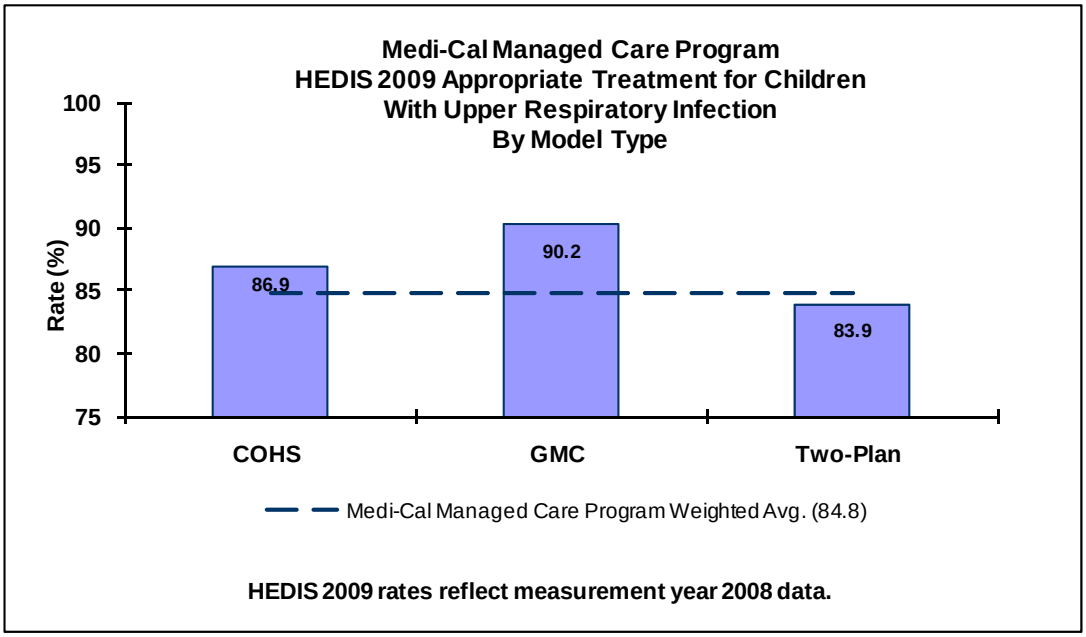
Americans suffer an estimated 1 billion URIs annually. Children have about three to eight URIs per year due to lack of exposure to prior infections and frequent contact with other children.[7] Although URIs are most often viral, antibiotics are frequently prescribed to children with this infection. With inappropriate antibiotic use, an individual can develop a resistance to antibiotics over time, making the medication ineffective. The United States spends approximately $227 million annually on inappropriate and unnecessary treatment of URIs.[8]

[7] National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed July 9, 2009.

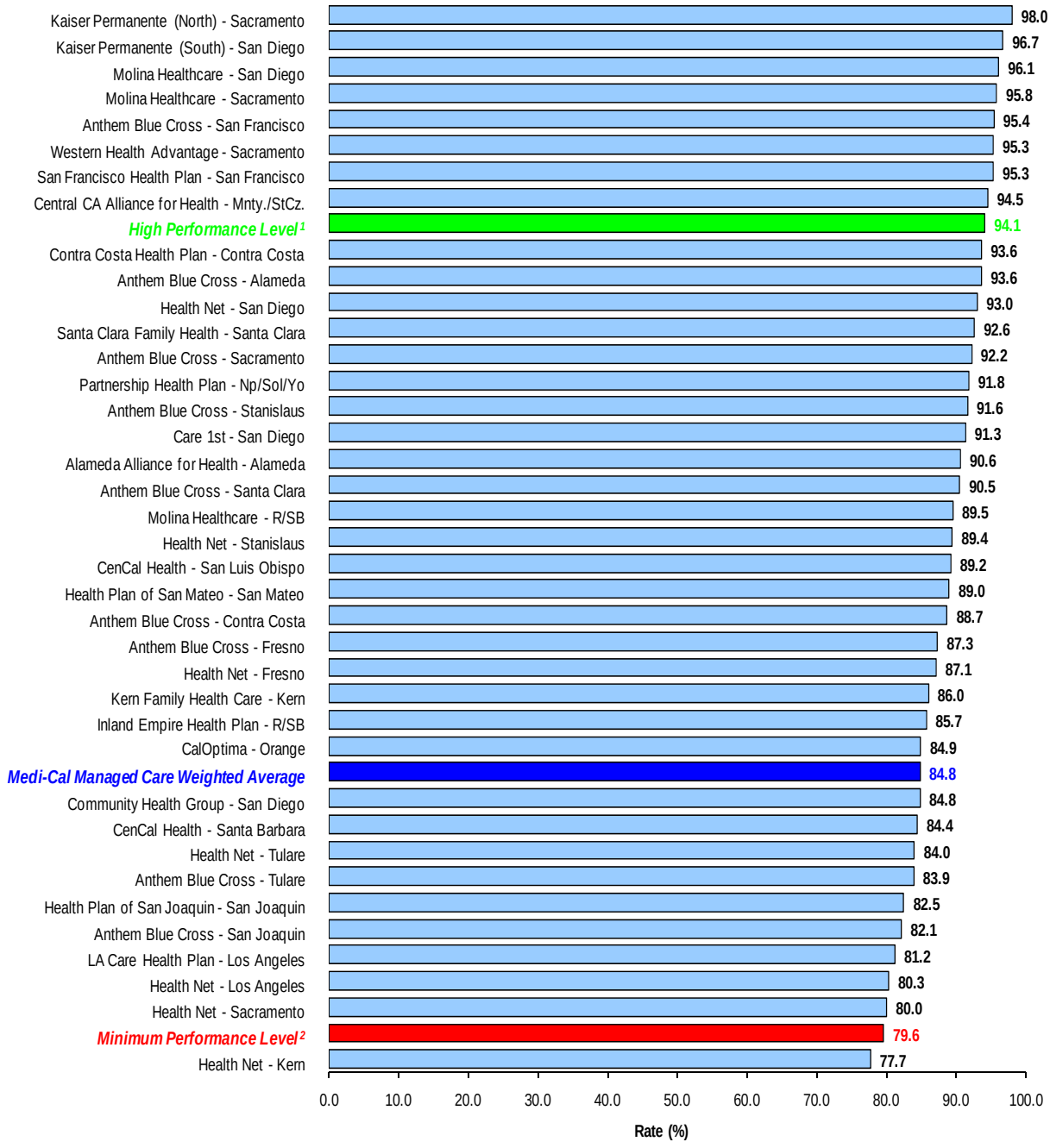
[8] Ibid

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Appropriate Treatment
for Children With Upper Respiratory Infection



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average showed a general increase since 2006, consistent with national trends for Medicaid and commercial averages.

High and Low Performers

Eight plans performed above the established HPL of 94.1. Only one plan, Health Net—Kern County, fell below the MPL, despite a statistically significant improvement over its 2008 rate. Fifteen of the 38 plans showed statistically significant improvement in 2009 compared with 2008 plan rates, and three plans had a statistically significant decrease.

The top four performing plans were GMC model types operating in Sacramento and San Diego counties by Kaiser Permanente and Molina Healthcare. The GMC model type outperformed the COHS and Two-Plan model types.

Best Practices

Five plans operating in 13 counties participated in a small-group collaborative QIP aimed at increasing appropriate treatment for children with a URI. In addition, another plan initiated an individual QIP focused on the same topic. Of these six plans, five showed statistically significant improvement in their 2009 rates compared to their 2008 rates in some or all of their operating counties.

The small-group collaborative (SGC) began in 2005 with plans implementing the majority of targeted provider and member interventions during the 2007 calendar year. The SGC plans worked in coordination with the California Medical Association's Alliance Working for Antibiotic Resistance Education (AWARE) and developed the Antibiotic Awareness Provider Toolkit, which they mailed to providers. Beginning in 2008, the plans mailed information to contracted PCPs that described the URI QIP and the importance of prescribing antibiotics appropriately, as well as a customized report of each PCP's member diagnosed with a URI who may have been inappropriately prescribed antibiotics in the last year. The report also included an overall rate for the PCP, the rate for the PCP's participating physician group (if applicable), and the plan rate. The plans' concerted efforts on the collaborative QIP may have contributed to the sustained improvement achieved by most of the collaborating plans.

Avoidance of Inappropriate Antibiotic Treatment in Adults With Acute Bronchitis

Measure Definition

This measure calculates the percentage of adults 18 to 64 years of age who were diagnosed with acute bronchitis and who were not dispensed an antibiotic prescription.

Importance

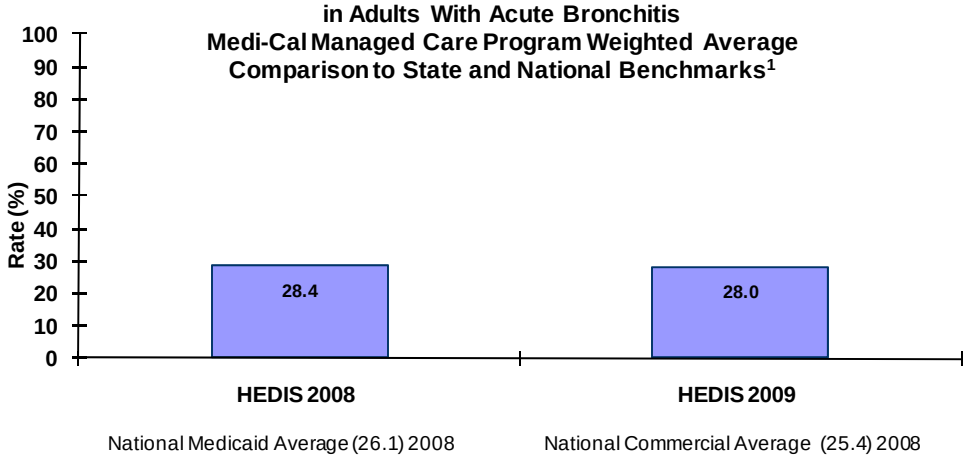
The Institute of Medicine (IOM) cites antibiotic resistance as one of the key microbial threats to health in the United States. The IOM promotes the appropriate use of antimicrobials as a primary means to address this threat.

The Centers for Disease Control and Prevention (CDC) also cites antimicrobial resistance as a major concern. The campaign, Get Smart: Know When Antibiotics Work, seeks to reduce the rising rate of antibiotic resistance. This campaign specifically targets the five respiratory conditions that in 1992 accounted for more than 75 percent of all office-based prescribing for all ages combined: otitis media (earache), sinusitis, pharyngitis (sore throat), bronchitis, and the common cold.[9] Although antibiotic prescribing rates have decreased, patients of all ages are prescribed more than 10 million courses of antibiotics annually for viral conditions that do not benefit from antibiotics.

According to the CDC, taking antibiotics when they are not needed can be harmful. Most often, a virus causes acute bronchitis; therefore, prescribing an antibiotic does not provide a therapeutic benefit.

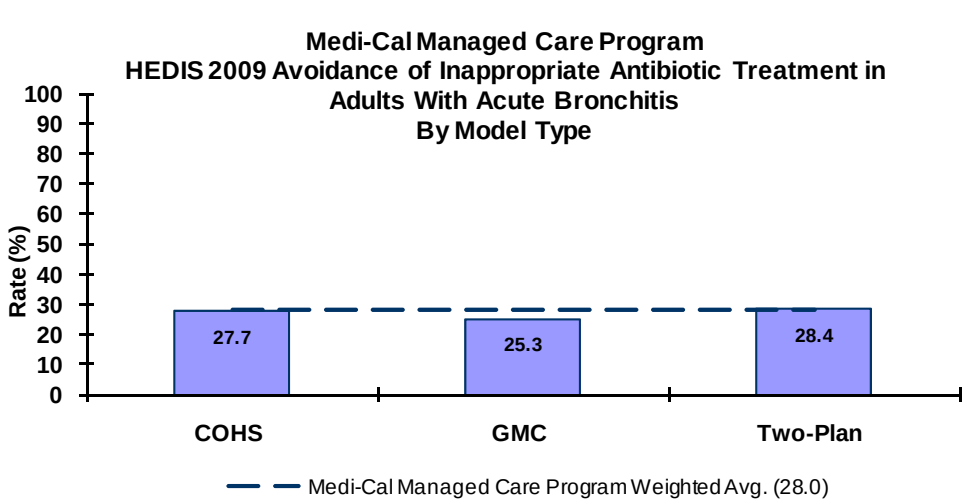
[9] Centers for Disease Control and Prevention. Get Smart: Know When Antibiotics Work. Available at: http://www.cdc.gov/getsmart/campaign-materials/about-campaign.html. Accessed September 9, 2009.

Performance Results



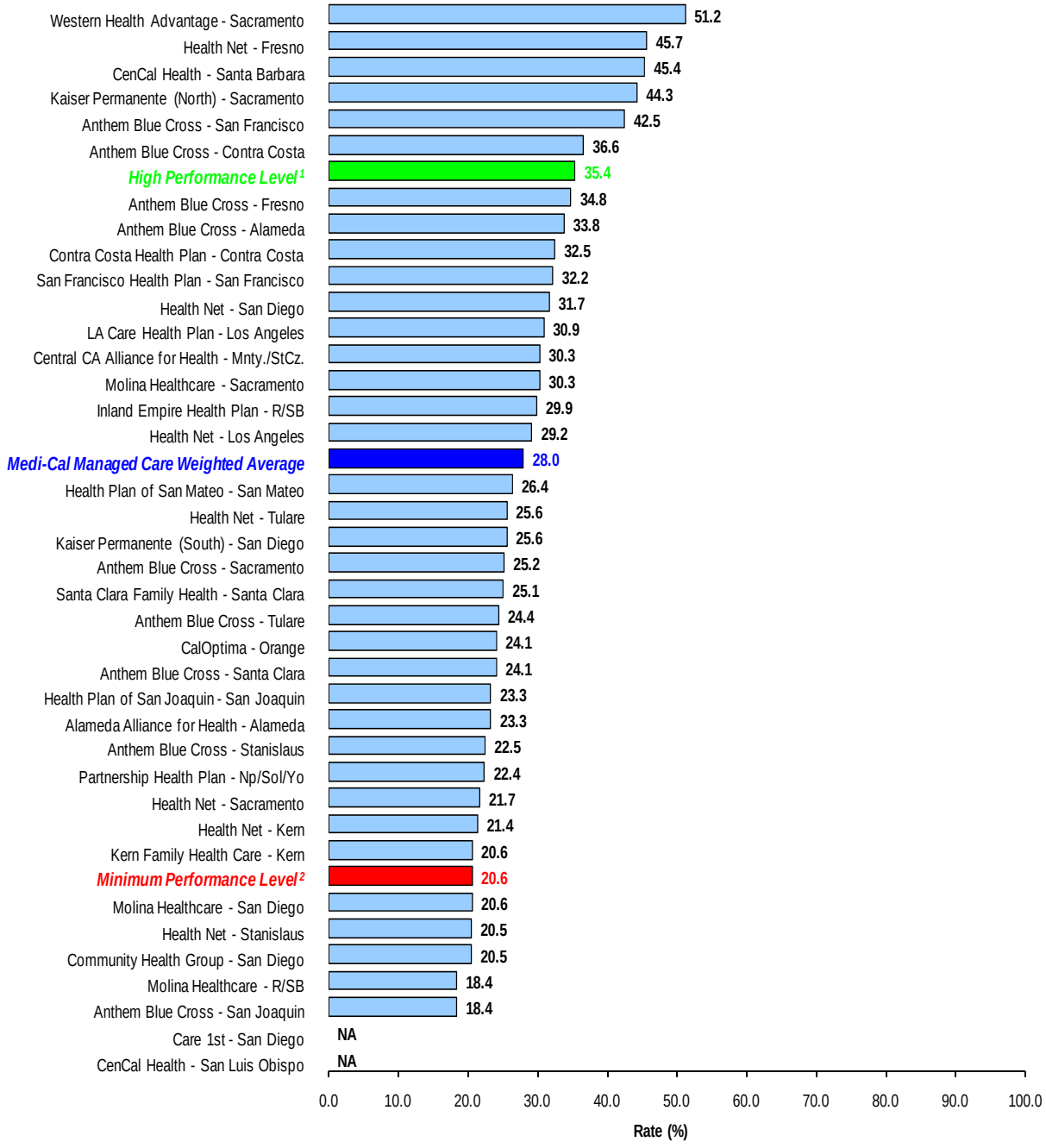
[1] For HEDIS 2006 and 2007, a lower rate represents better performance and are not displayed for comparison.

HEDIS 2009 rates reflect 2008 measurement year data.



HEDIS 2009 rates reflect measurement year 2008 data.

Medi-Cal Managed Care
HEDIS 2009 Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's 2009 weighted average for *Avoidance of Inappropriate Antibiotic Treatment in Adults With Acute Bronchitis* decreased only slightly from the 2008 weighted average. The 2008 MCMC weighted average exceeded both the national Medicaid and commercial averages. For this measure only, prior to 2008, plans reported an inverted rate. Beginning in 2008, a higher rate indicated better performance; therefore, HSAG omitted the 2007 MCMC weighted average from the table since trending was not comparable this year.

High and Low Performers

Six plans performed above the established HPL and four plans fell below the MPL. CalOptima—Orange County and Health Net—Fresno County had statistically significant increases in 2009 compared to their 2008 rates. Health Net—Fresno County's increase propelled the plan above the HPL. Molina Healthcare—Riverside/San Bernardino counties and Molina Healthcare—San Diego County showed statistically significant decreases in 2009 compared to their 2008 rates with Molina Healthcare—Riverside/San Bernardino counties falling below the MPL. Health Net—Stanislaus County and Anthem Blue Cross—San Joaquin County had consistently poor performance in 2008 and 2009.

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

Best Practices

While plans have not specifically targeted inappropriate treatment of acute bronchitis in adults as a selected QIP topic in recent years, many plans worked with the California Medical Association's Alliance Working for Antibiotic Resistance Education (AWARE) and developed the Antibiotic Awareness Provider Toolkit, which they mailed to providers. This toolkit addresses acute bronchitis in adults and is a California-specific alternative to the CDC's *Get Smart* materials.

Western Health Advantage—Sacramento County, which performed above the HPL in 2009, indicated that the plan's primary activity related to this measure was disseminating the CDC's *Get Smart* materials to providers. The plan posted the materials to its Web site and shared the materials at medical director and quality improvement meetings. These activities may have contributed to the plan's high performance.

Efforts by the MCMC plans to target physicians are supported by a recent *Med Care* article addressing ways to reduce unnecessary antibiotic prescribing. A review of 43 studies determined that active clinician interventions generally were more effective than passive interventions.[10] Additionally, interventions that targeted both clinicians and patients were more effective than those targeting only clinicians or patients.

[10] Ranji, SR, Steinman, MA, et al. Interventions to reduce unnecessary antibiotic prescribing: a systematic review and quantitative analysis. Med Care. 2008. Aug; 46(8):847-62.

Breast Cancer Screening

Measure Definition

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 second leading cause of cancer deaths among women nationwide, as well as in the State of California.[11] The American Cancer Society estimates that the United States will have 192,370 new cases of breast cancer and 40,170 deaths from breast cancer during 2009.[12] The American Cancer Society also projects that 22,115 women will be newly diagnosed with breast cancer in California during 2009.[13]

A mammogram can detect breast cancer in its early stages, when treatment is more effective and a cure is more likely. Mammography can detect about 80 percent to 90 percent of breast cancers in women who do not have any symptoms.[14]

According to the California Cancer Registry, among women 30 to 64 years of age diagnosed with breast cancer in 1993, women with Medi-Cal benefits had a higher proportion of late-stage tumors, even after controlling for age, race/ethnicity, marital status, and education.[15] This finding suggests that women enrolled in Medi-Cal are less likely to be screened for breast cancer than other women in California. An opportunity exists to increase breast cancer screening rates among MCMC enrollees to improve health outcomes and decrease mortality.

In November 2009, the United States Preventive Services Task Force revised its biennial mammography screening recommendations to women 50 to 74 years of age.[16] This recommendation change could have an impact on measure definition in the future.

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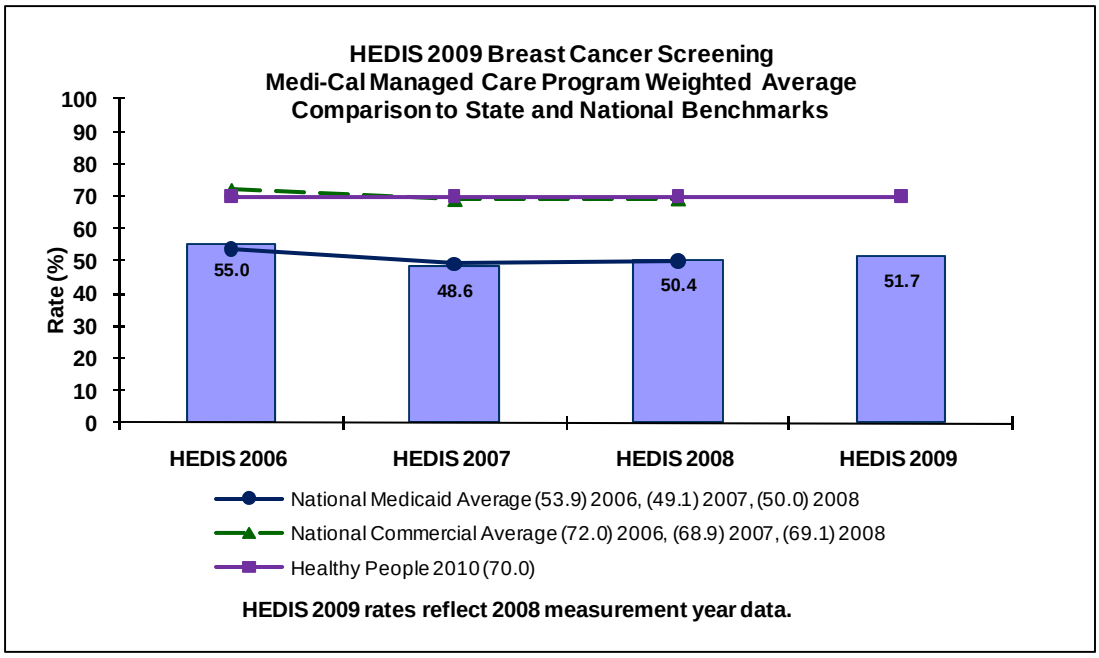
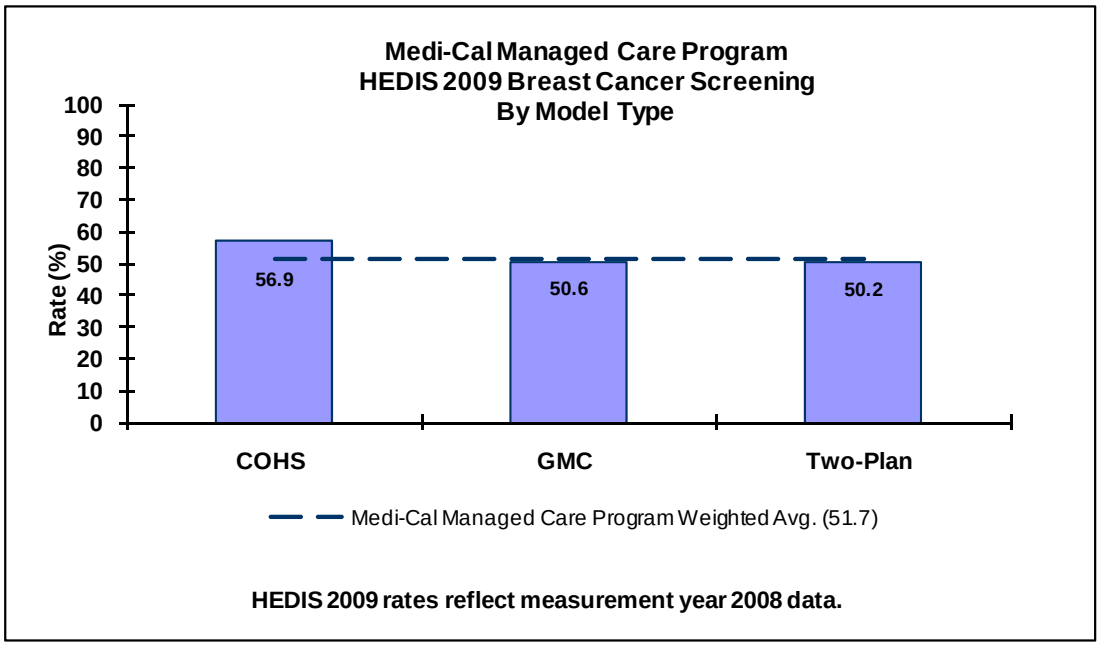
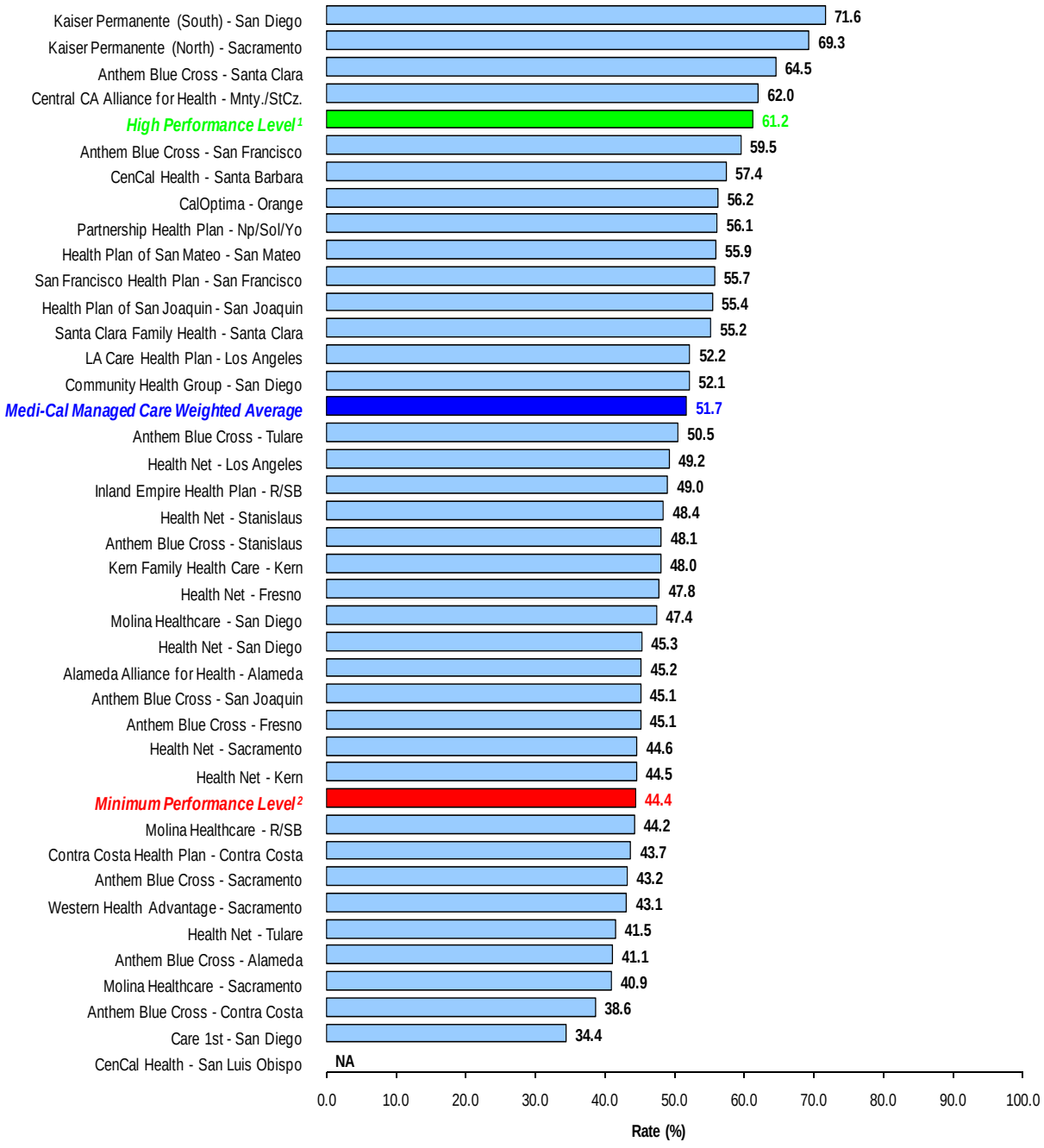
[11] American Cancer Society, Cancer Facts & Figures 2009. Available at: http://www.cancer.org/downloads/STT/500809web.pdf. Accessed July 9, 2009.
[12] Ibid.
[13] American Cancer Society, California Division and Public Health Institute, California Cancer Registry. California Cancer Facts and Figures 2009. Oakland, CA: American Cancer Society, California Division, September 2008. http://www.ccrcal.org/PDF/ACS2009.pdf. Accessed October 2, 2009.
[14] Ibid.
[15] Perkins CI, Allen MA, Wright WE, Takahashi E, Stoodt G, Cohen R. Breast cancer in California: stage at diagnosis and Medi-Cal status. Sacramento, CA: California Department of Health Services, Cancer Surveillance Section, March 2000. http://www.ccrcal.org/PDF/Med-Cal.pdf. Accessed October 2, 2009.
[16] Agency for Healthcare Research and Quality, U.S. Preventive Services Task Force. Screening for Breast Cancer, Release date, November 2009. http://www.ahrq.gov/clinic/uspstf/uspsbrca.htm. Accessed July 2010.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Breast Cancer Screening



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's 2009 weighted average for *Breast Cancer Screening* increased slightly from the 2008 weighted average rate, although the increase was not statistically significant. Despite the large decrease in 2007 compared to 2006, the MCMC weighted average has shown an increase each year for the last two years. The MCMC weighted average followed a consistent trend with the national Medicaid average, although it fell significantly below the national commercial average and the Healthy People 2010 goal of 70 percent.

High and Low Performers

Four plans performed above the established HPL in 2009. Kaiser Permanente (North)—Sacramento County, Kaiser Permanente (South)—San Diego County, and Anthem Blue Cross—Santa Clara County showed consistently high performance by being the only three plans to achieve the HPL in 2008 and 2009. Central California Alliance for Health—Monterey/Santa Cruz counties also achieved the HPL in 2009.

Nine plans performed below the MPL in 2009 compared to six in 2008. Of these nine, four plans, Molina Healthcare—Riverside/San Bernardino counties, Western Health Advantage—Sacramento County, and Anthem Blue Cross' Alameda and Contra Costa counties, also fell below the MPL in 2008.

Five plans had statistically significant improvement in their 2009 rates compared to 2008 rates, and three plans had statistically significant decreases.

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

Best Practices

The Task Force on Community Preventive Services, an independent, nonfederal, volunteer body of public health and prevention experts whose members are appointed by the Director of the Centers for Disease Control and Prevention, conducts systematic reviews of interventions and makes recommendations for those who promote public health. These evidence-based recommendations are provided within the Community Guide.[17] The guide's findings for increasing breast cancer screening provide both client-oriented and provider-oriented screening interventions. Client-oriented recommendations include the following:

- Client reminders
- Small media (videos and printed materials such as letters, brochures, and newsletters)
- One-on-one education

[17] Guide to Community Preventive Services. Cancer prevention and control: client-oriented screening interventions. www.thecommunityguide.org/cancer/screening/client-oriented/index.html.

- Reducing structural barriers (distance from screening location, limited hours of operation, lack of day care for children, and language and cultural factors)
- Reducing out-of-pocket costs

The Community Guide recommends provider assessment and feedback along with provider reminders and recall as effective provider-oriented interventions.

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

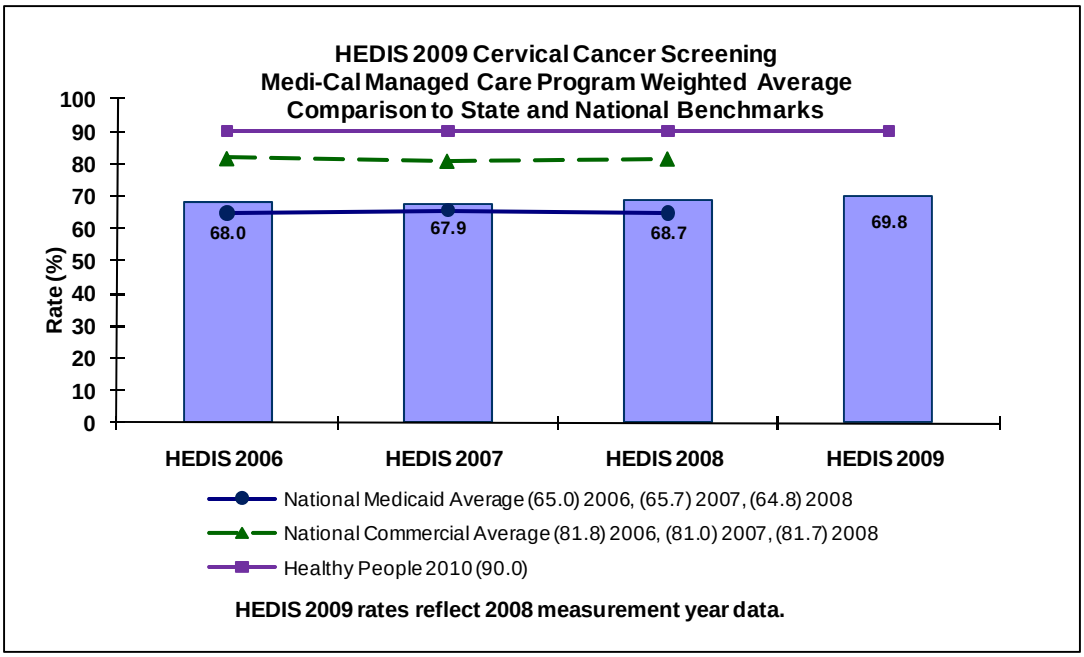
According to the American Cancer Society, regular cervical cancer screening can prevent cancer of the cervix by finding pre-cancers before they become invasive cancer.[18] The Pap test (or Pap smear) is the most common screening test, and if a pre-cancer is found and treated, it can stop cervical cancer before it starts.

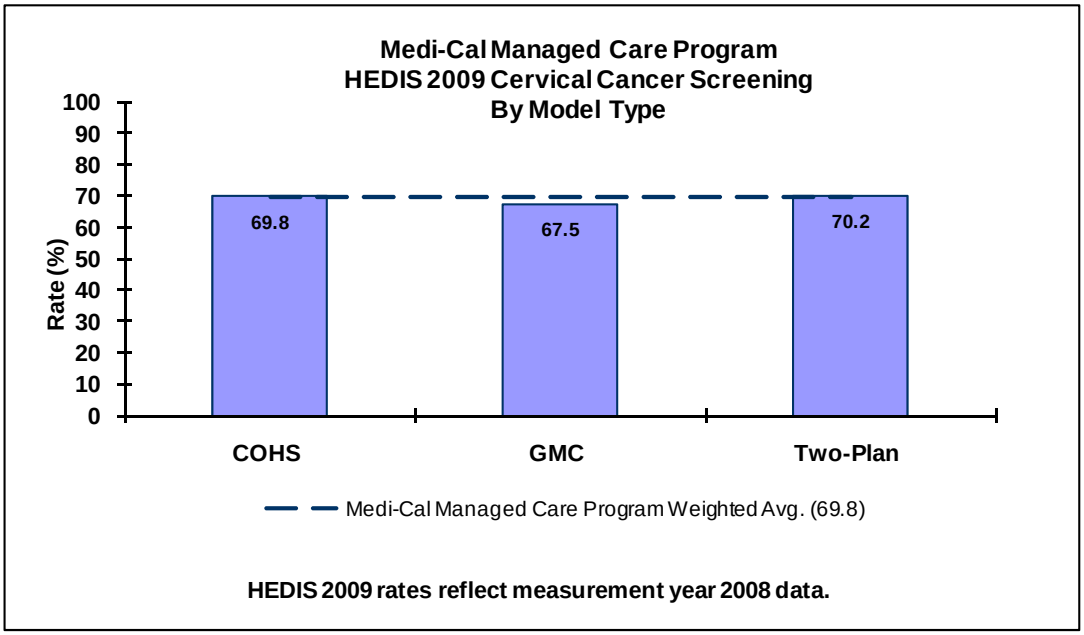
Once cancer develops, early detection greatly improves the chances of successful treatment of cervical cancer. The five-year survival rate is 92 percent for women diagnosed with localized cervical cancer.[19]

Most invasive cervical cancers are found in women who have not had regular Pap tests.[20] This finding supports the importance of regular cervical cancer screenings.

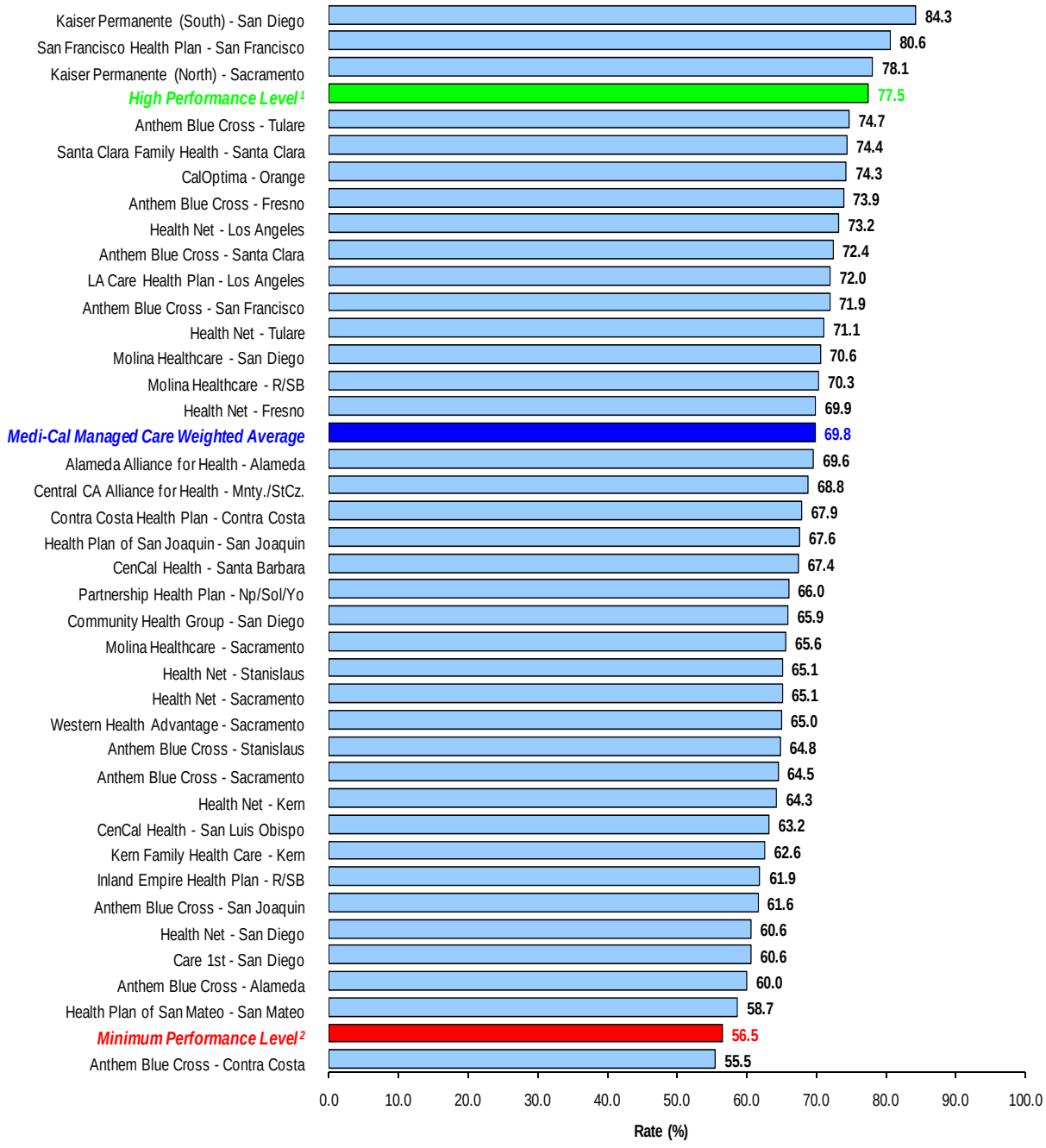
[18] American Cancer Society, Overview of Cervical Cancer. Available at: http://www.cancer.org/. Accessed October 2, 2009.
[19] American Cancer Society, Cancer Facts & Figures 2009. Available at: http://www.cancer.org/downloads/STT/500809web.pdf. Accessed July 10, 2009.
[20] Ibid.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Cervical Cancer Screening



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's 2009 weighted average for *Cervical Cancer Screening* increased slightly from the 2008 weighted average rate, although the increase was not statistically significant. The MCMC Program's weighted average from 2006 to 2008 exceeded the national Medicaid average over the last three years but was significantly lower than the national commercial average, as well as the Healthy People 2010 goal of 90 percent.

High and Low Performers

Similar to the 2008 results, three plans performed above the HPL. Both Kaiser plans continued to remain above the HPL, with Kaiser Permanente (South)—San Diego County showing statistically significant improvement in 2009 compared to its 2008 rate. In addition, San Francisco Health Plan—San Francisco County reached the HPL in 2009 with statistically significant improvement over its 2008 rate.

Only one plan, Anthem Blue Cross—Contra Costa County, performed below the MPL in 2009, a reduction from four plans in 2008.

The GMC model type did not perform as well as the COHS and Two-Plan model types and was below the MCMC weighted average.

Best Practices

The Community Guide's recommendations to increase cervical cancer screening are similar to those recommended for breast cancer screening.[21] Effective client-oriented interventions include the following:

- Client reminders
- Small media (videos and printed materials such as letters, brochures, and newsletters)
- One-on-one education
- Reducing out-of-pocket costs

Provider-oriented interventions include assessment and feedback on a provider's or group's performance relative to a standard or goal and/or mechanisms to alert a provider that it is time for a client's cervical cancer screening.

The Community Guide found insufficient evidence due to inconsistent results to support provider incentives to increase cervical cancer screening rates. However, the DHCS includes cervical cancer screening as part of its auto-assignment program, and it is unclear if this inclusion has helped to increase performance above the Medicaid national average.

[21] Guide to Community Preventive Services. Cancer prevention and control: client-oriented screening interventions. www.thecommunityguide.org/cancer/screening/client-oriented/index.html.

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 on or before their second birthday: four diphtheria, tetanus, and pertussis (DTaP); three inactivated poliovirus (IPV); one measles, mumps, and rubella (MMR); two Haemophilus infuenzae type b (Hib); three hepatitis B; one varicella-zoster virus (chicken pox or VZV); and four pneumococcal conjugate vaccinations.

Importance

Over the last 50 years, childhood vaccination has led to dramatic declines in the occurrence of many life-threatening diseases such as polio, tetanus, whooping cough, mumps, measles, and meningitis. In children who are not vaccinated, these diseases can cause blindness, hearing loss, diminished motor functioning, liver damage, coma, and death. For example, discontinuing the Hib immunization would result in approximately 20,000 cases per year of invasive disease and 600 deaths.[22]

The CDC recommends that children from birth to 6 years of age receive the following vaccinations: hepatitis B, rotavirus, DTaP, Hib, pneumococcal, IPV, influenza, MMR, VZV, hepatitis A, and meningococcal.[23]

California ranked 31st in terms of immunization coverage in 2008, according to the United Health Foundation, with 77.1 percent of children 19 to 35 months of age receiving four or more doses of DTaP, three or more doses of IPV, one or more doses of any measles-containing vaccine, three or more doses of Hib, and three or more doses of hepatitis B vaccine.[24]

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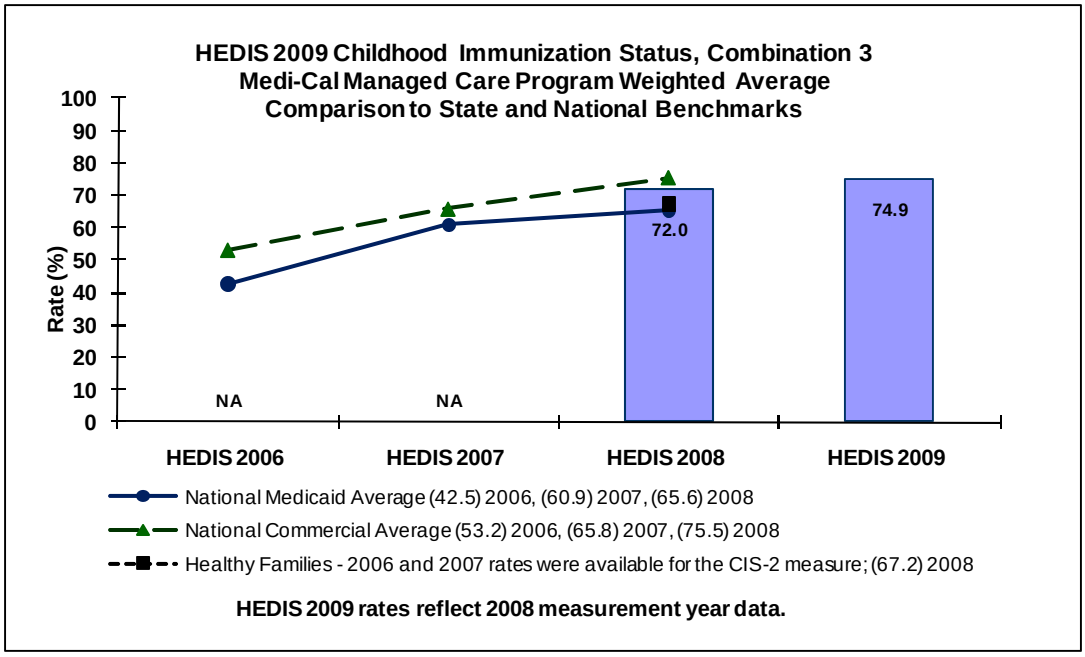
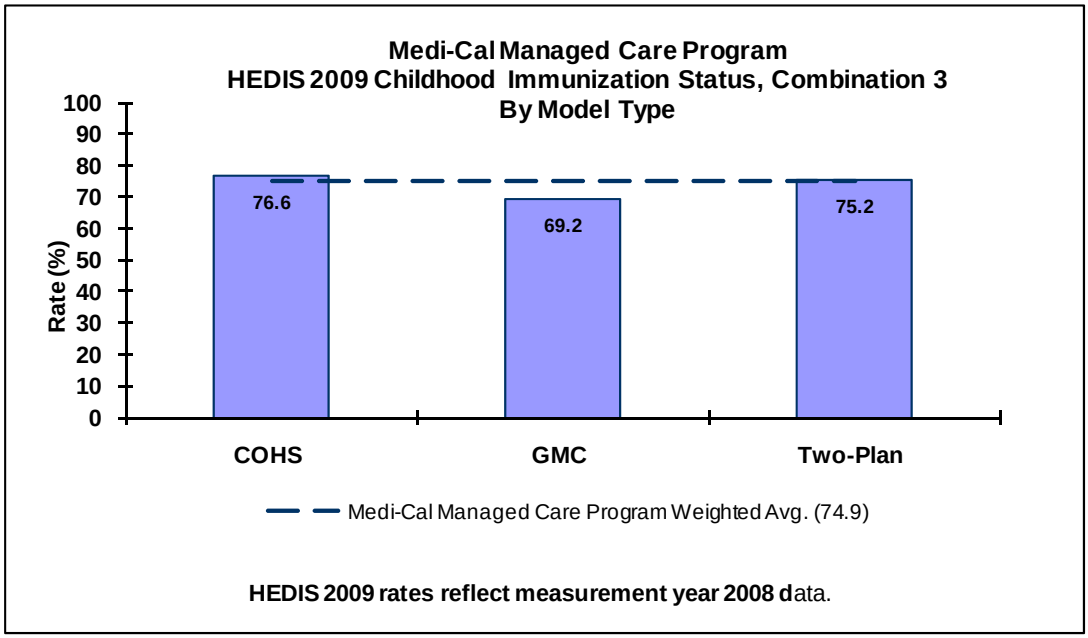
[22] National Committee for Quality Assurance. The State of Health Care Quality 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed August 31, 2009.

[23] Centers for Disease Control and Prevention. 2009 Child & Adolescent Immunization Schedules. Available at: http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm. Accessed August 31, 2009.

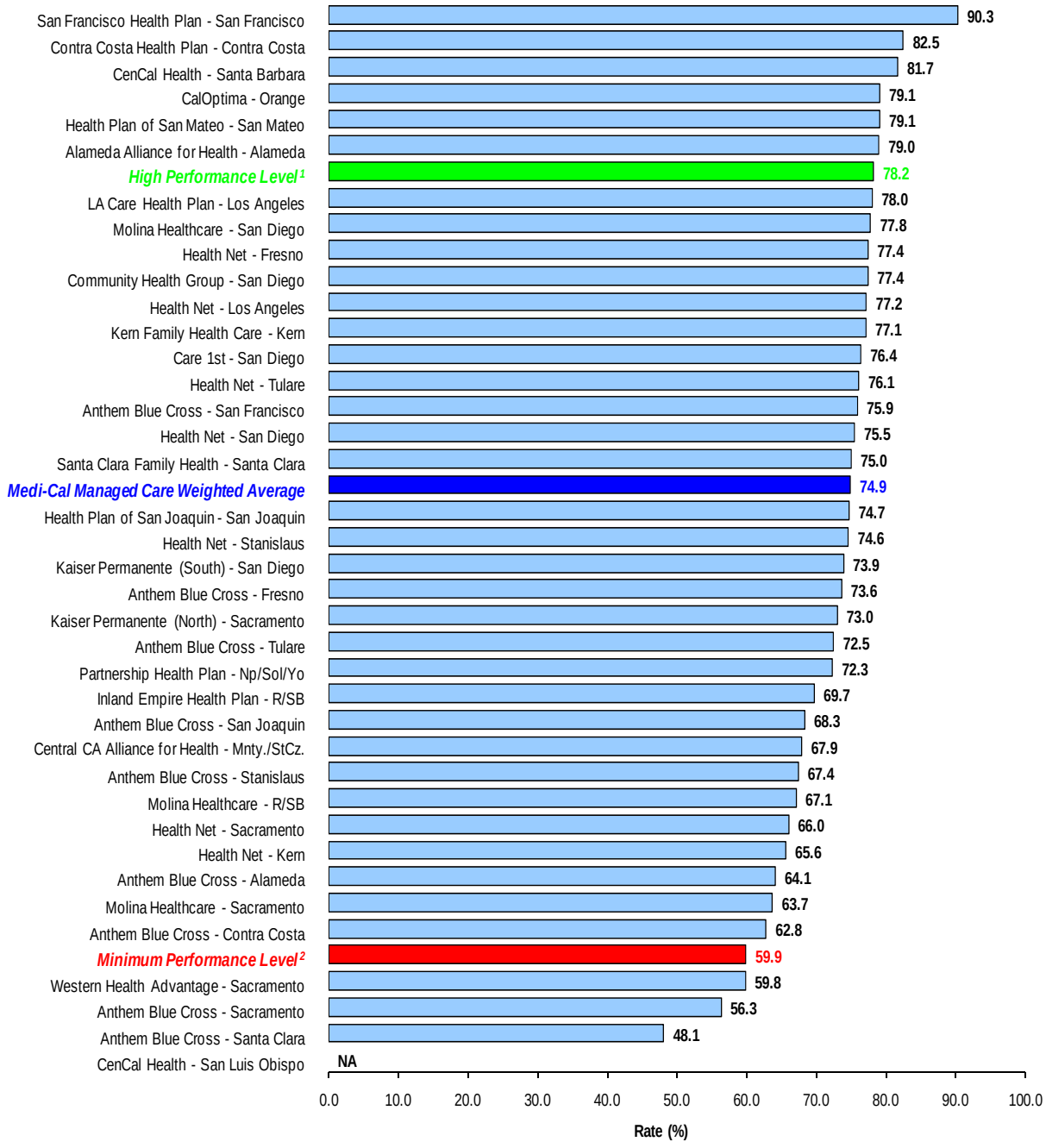
[24] United Health Foundation. America's Health Rankings. Available at: http://www.americashealthrankings.org/2008/pdfs/co.pdf. Accessed August 31, 2009.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Childhood Immunization Status, Combination 3



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average showed a statistically significant increase in 2009 compared with 2008. The MCMC Program's weighted average was above the national Medicaid average in 2008 but below the national commercial average. The DHCS began requiring the *Childhood Immunization Status—Combination 3* measure in 2008; therefore, trending prior to 2008 was not applicable.

High and Low Performers

Since the DHCS considered this a first-year measure in 2008, it did not publically report 2008 plan rates, nor did it apply prior-year MPLs or HPLs.

In reporting year 2009, six plans performed above the HPL of 78.2 percent, while three plans fell below the MPL of 59.9 percent. This measure was part of the DHCS's auto-assignment program, with the DHCS using the *Combination 2* measure prior to adopting the *Combination 3* measure. The auto-assignment program may have played a role in MCMC overall performing above the Medicaid national average and the statistically significant improvement over the 2008 rates.

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

Rates for eight plans showed statistically significant improvement over their 2008 rates, while three plans had a statistically significant decrease.

Best Practices

The implementation of numerous interventions has increased immunization rates. A review of 41 studies that evaluated the effect of using patient reminder/recall interventions found them to be effective.[25] Among these, telephone reminders were the most effective, followed by tracking and outreach and the combination of patient and provider prompts.

Literature also documented that multi-component interventions that included education were the most effective in increasing vaccination rates.[26] According to the literature, these interventions were effective across different ethnic and age groups. Provider reminders and provider feedback were both associated with increases in immunization rates.

[25] Szilagyi, PG, Bordley, C, Vann, JC, et al. Effect of Patient Reminder/Recall Interventions on Immunization Rates: A Review. JAMA. 2000. 284(14):1820-1827.

[26] Shefer, A, Briss, P, Rodewald, L, et al. Improving Immunization Coverage Rates: An Evidence-based Review of the Literature. Epidemiological Reviews. 1999. 21(1):96-142.

Using a stepped intervention approach also resulted in improved rates of immunizations and well-child visits.[27] The steps included first mailing reminders to members, followed by several attempts to contact nonresponding members by phone, followed by case management and/or visits to those who were still not immunized.

Childhood Immunization Status is a HEDIS measure that is often the study topic for QIPs. The interventions observed by HSAG, excluding the interventions mentioned previously, include the following:

- Using immunization registries
- Providing incentives to providers who report to an immunization registry
- Providing electronic prompts to providers for needed immunizations

Similar to the article findings, multi-component interventions were most often associated with sustained increases in immunization rates.

Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing

Measure Definition

The *Comprehensive Diabetes Care—Hemoglobin A1c (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 tests within the last year.

Importance

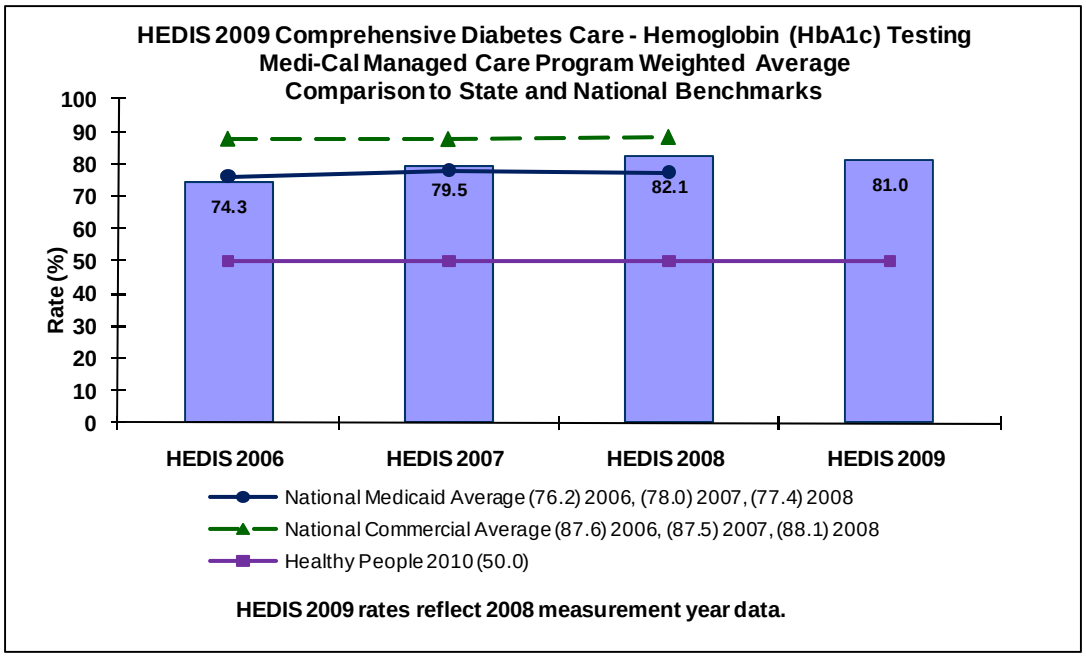
HbA1c testing (a hemoglobin A1c test or glycosylated hemoglobin test) is accomplished by measuring attached glucose in a current blood sample and shows the average blood glucose level over the past two to three months. HbA1c test results are expressed as a percentage, and a result between 4 and 6 percent is considered normal.

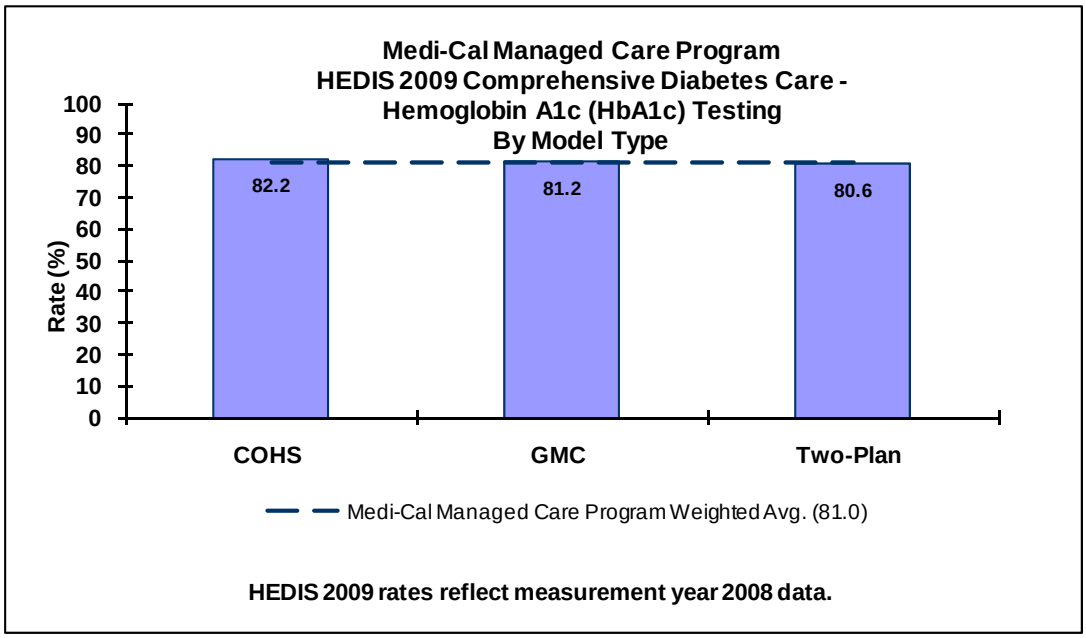
Diabetics who maintain near-normal HbA1c levels gain, on average, an extra five years of life, eight years of eyesight, and six years of freedom from kidney disease.[28]

[27] Hambridge, SJ, Phibbs, SL, et al. A Stepped Intervention Increases Well_Child Care and Immunization Rates in a Disadvantaged Population. Pediatrics. 2009. 124(2):455

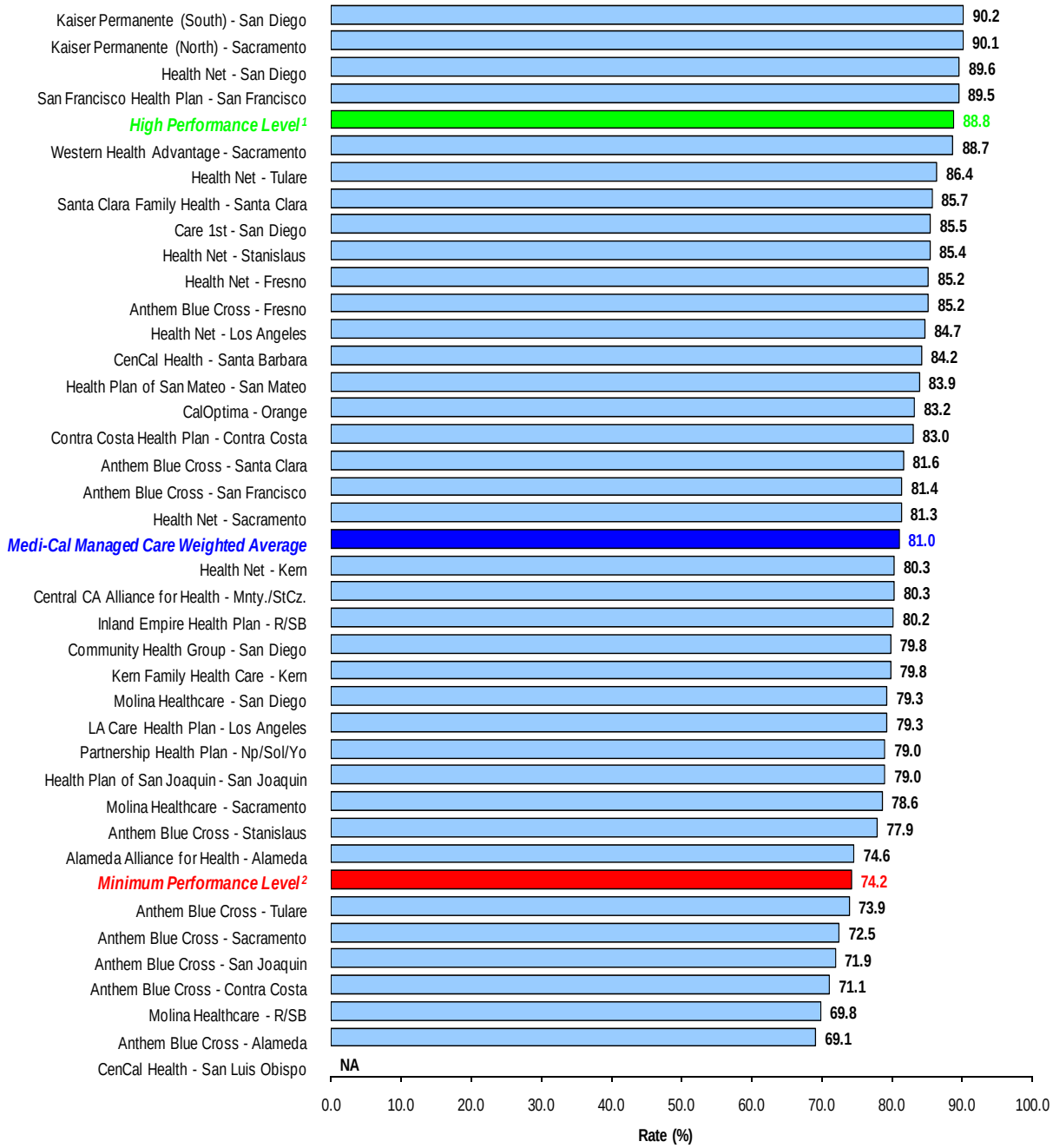
[28] National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed September 15, 2009.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Testing



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average has shown a general trend of increasing rates from 2006 to 2008, with a slight decrease in 2009 compared to 2008 that was not statistically significant. The program's average exceeded the national Medicaid average in 2007 and 2008, as well as the Healthy People 2010 goal from 2006 through 2009. The program's average, however, has yet to exceed the national commercial average.

High and Low Performers

Four plans performed above the HPL in 2009 compared with two plans performing above the HPL in 2008. Kaiser Permanente (North)—Sacramento County and Kaiser Permanente (South)—San Diego County performed above the HPL in 2008 and 2009, with San Francisco Health Plan—San Francisco County and Health Net—San Diego County achieving the HPL in 2009. Six plans fell below the MPL, of which five demonstrated low performance in 2008 by either falling below the MPL or performing just above the MPL. One exception was the rate for Anthem Blue Cross—Tulare County, which fell from 82.2 percent in 2008 to 73.9 percent in 2009, a statistically significant decrease.

Only three plans had statistically significant improvement over their 2008 rates, while five plans showed a statistically significant decrease.

The DHCS will add this measure to its auto-assignment program in 2010, which may have an impact on plans' performance in the future.

All three model types performed relatively consistent with one another and very close to the MCMC weighted average.

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

Measure Definition

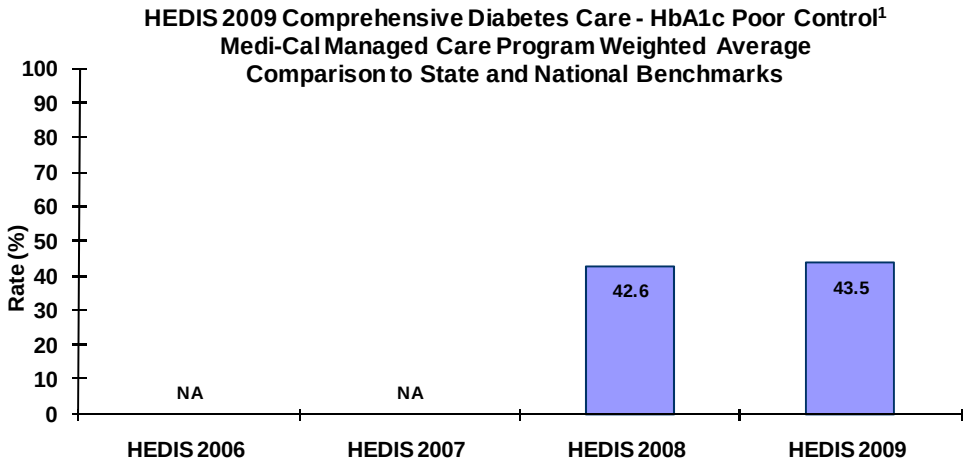
The *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) whose most recent HbA1c test conducted during the year showed a greater than 9 percent HbA1c level, indicating poor control.

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

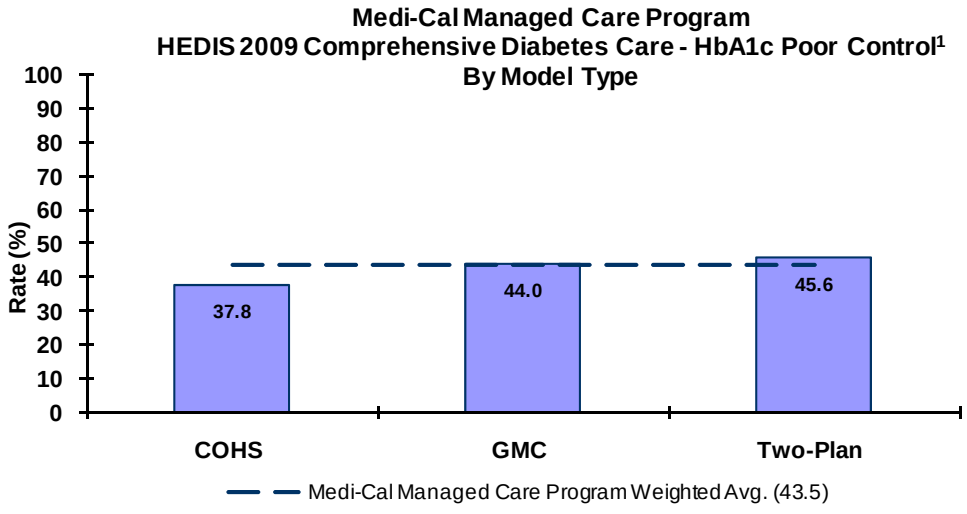
blood glucose levels in people with diabetes significantly reduces the risk of blindness, end-stage renal disease (ESRD), and lower extremity amputation.

Performance Results



[1] A lower rate indicates better performance.

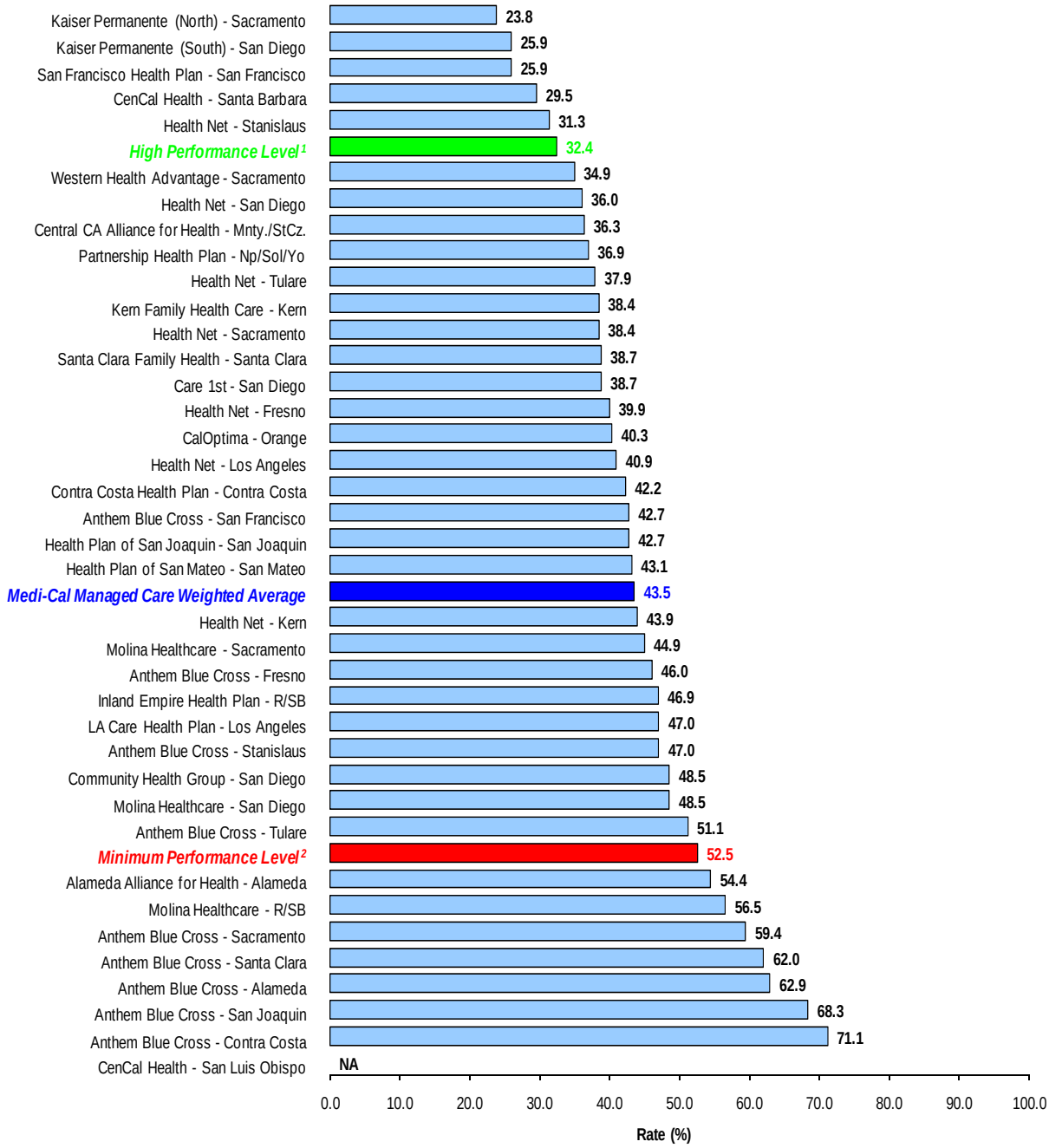
HEDIS 2009 rates reflect 2008 measurement year data.



[1] A lower rate indicates better performance.

HEDIS 2009 rates reflect measurement year 2008 data.

Medi-Cal Managed Care
HEDIS 2009 Comprehensive Diabetes Care - HbA1c Poor Control[3]



[1] High Performance Level is HEDIS 2008 national Medicaid 10th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 75th Percentile.
[3] A lower rate indicates better performance.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

For this measure, a lower rate indicates better performance. The MCMC Program's weighted average showed a slight increase, indicating poorer performance in 2009 compared to 2008, although the change was not statistically significant. The program demonstrated better performance compared to the national Medicaid average for 2008, but the program's weighted average was worse than the national commercial average. These findings suggest that while HbA1c tests among diabetic members were consistently performed by MCMC plan providers over the last several years, blood sugar itself was not well controlled. The DHCS added this measure to the required EAS in 2008; therefore, as plans begin to collect this data and review their individual plan results, they will have an opportunity to impact future performance.

High and Low Performers

The DHCS applied an HPL and MPL to this measure for the first time in 2009. Five plans exceeded the 2009 HPL while seven plans did not achieve the MPL, with the Anthem Blue Cross plans accounting for five of the seven.

Six plans showed statistically significant improvement over their 2008 rates. Another six plans had statistically significant declines in performance from their 2008 rates, with the Anthem Blue Cross plans accounting for five of the six.

The COHS model type outperformed both the Two-Plan and GMC model types and performed better than the MCMC weighted average.

Comprehensive Diabetes Care—HbA1c Control (<7.0 Percent)

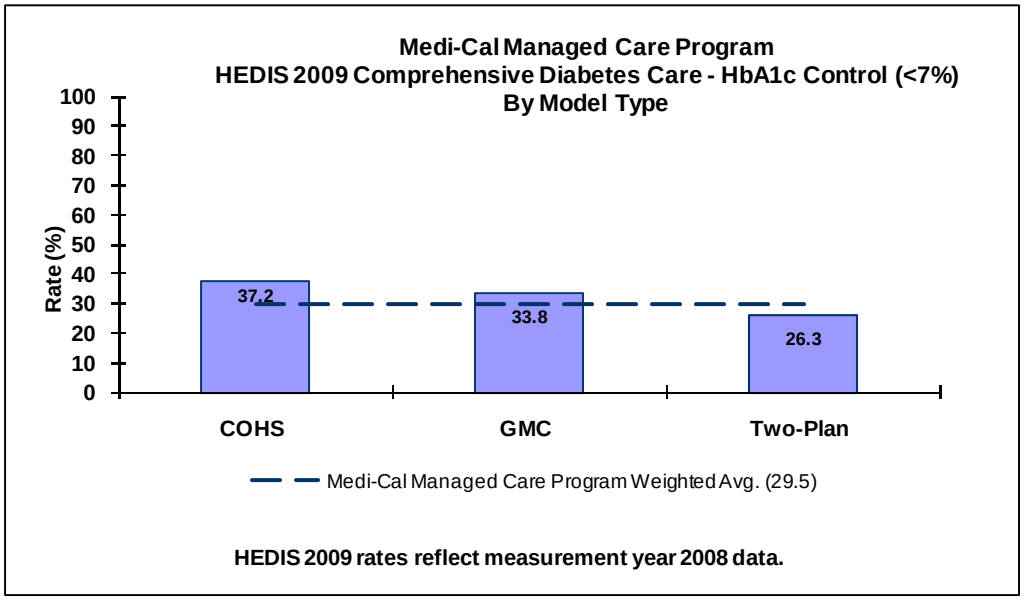
Measure Definition

The *Comprehensive Diabetes Care—HbA1c Control (<7.0 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 7 percent.

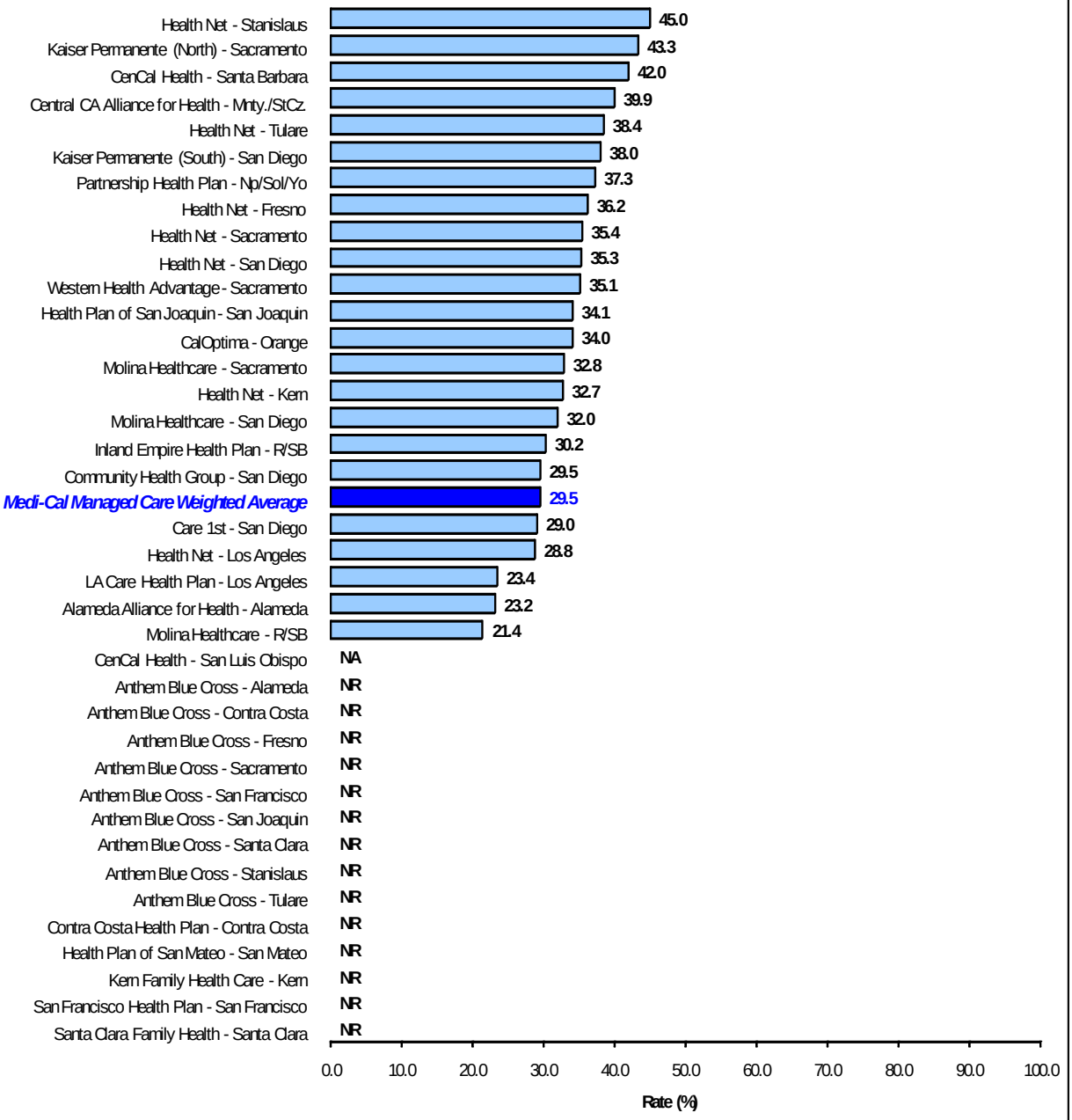
Importance

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

Performance Results



Medi-Cal Managed Care
HEDIS 2009 Comprehensive Diabetes Care - HbA1c Control (<7%)



The Minimum Performance Level and High Performance Level were not applied to this measure due to significant methodology changes from the prior year.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average was 29.5 percent for this measure in 2009. Due to significant methodology changes to this measure, no comparisons to prior years are displayed, and national benchmarks for 2008 are omitted.

High and Low Performers

The DHCS did not apply an MPL or HPL to this measure in 2009 because of the methodology changes. Fourteen plans received a *Not Report* for this measure because they had difficulty achieving the required sample size, often due to a high number of unexpected member exclusions. For many plans, the added cost to re-sample and abstract medical records to report a valid rate was a barrier, and some plans opted to receive a *Not Report*.

For the plans that reported rates, the COHS model type outperformed both the GMC and Two-Plan models and exceeded the MCMC 2009 weighted average.

The DHCS will eliminate this measure from its EAS in 2010 and replace it with the *HbA1c Control (<8.0 Percent)* measure, which will allow plans and the DHCS to monitor control while alleviating some of the challenges plans experienced during 2009.

Comprehensive Diabetes Care—Low-Density Lipoprotein–Carbohydrate (LDL-C) Screening

Measure Definition

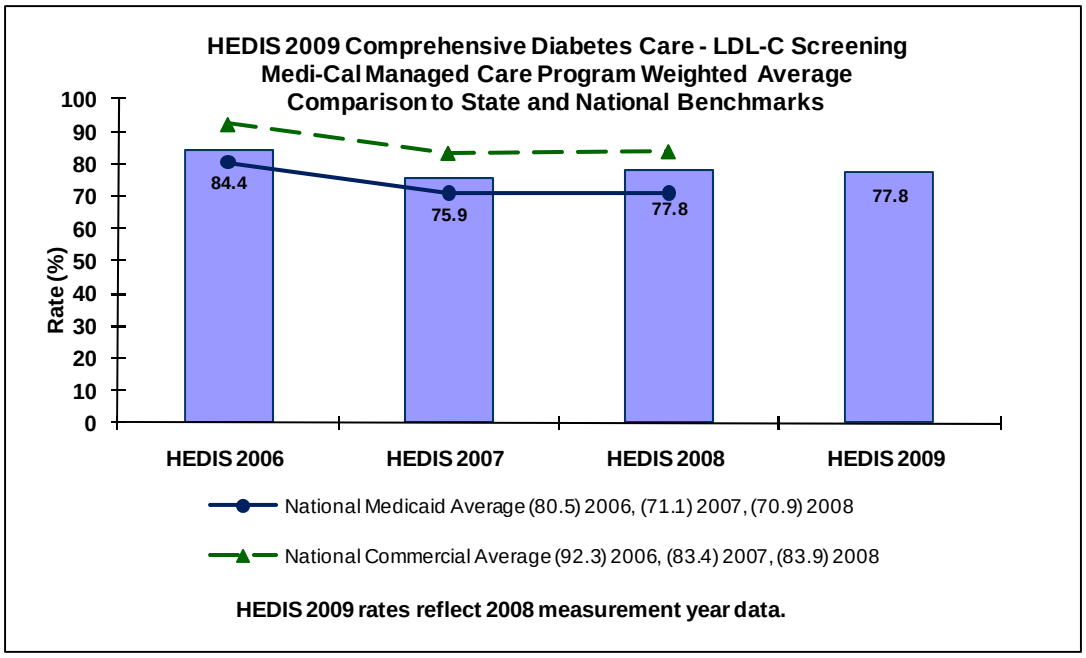
The *Comprehensive Diabetes Care—LDL-C Screening* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who had an LDL-C test within the last two years.

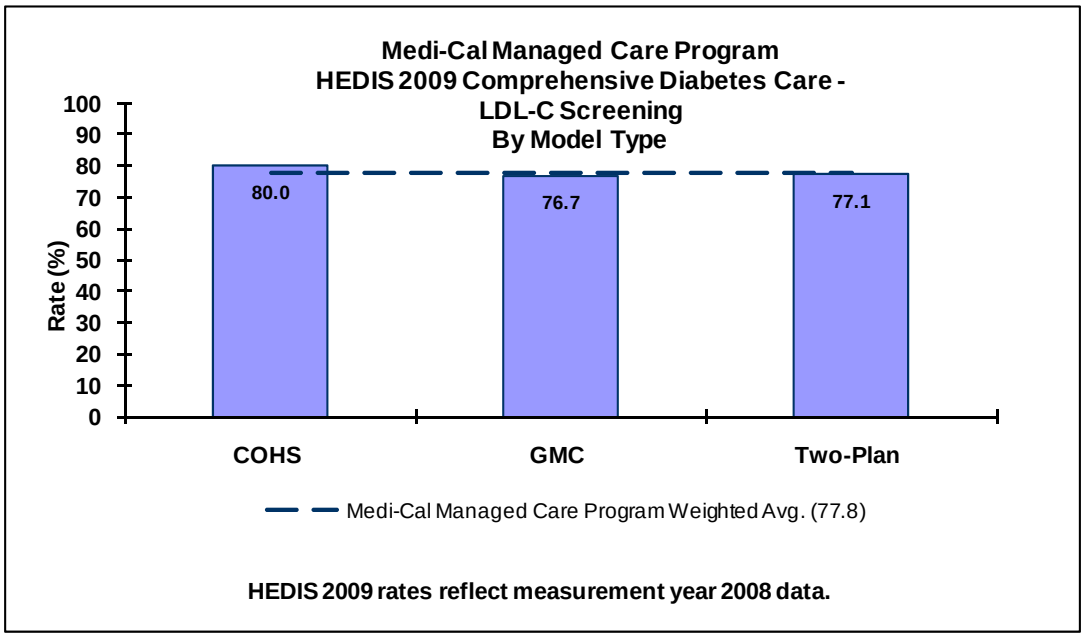
Importance

People with diabetes are at an increased risk for heart disease. According to the American Diabetes Association, two out of three people with diabetes die from heart disease and stroke.[29] Low-density lipoprotein (LDL) is a type of lipoprotein that carries cholesterol in the blood. LDL (often referred to as "bad" cholesterol) is undesirable because it deposits excess cholesterol in the walls of blood vessels and contributes to atherosclerosis (hardening of the arteries) and heart disease. The test for LDL measures the amount of LDL cholesterol in the blood.

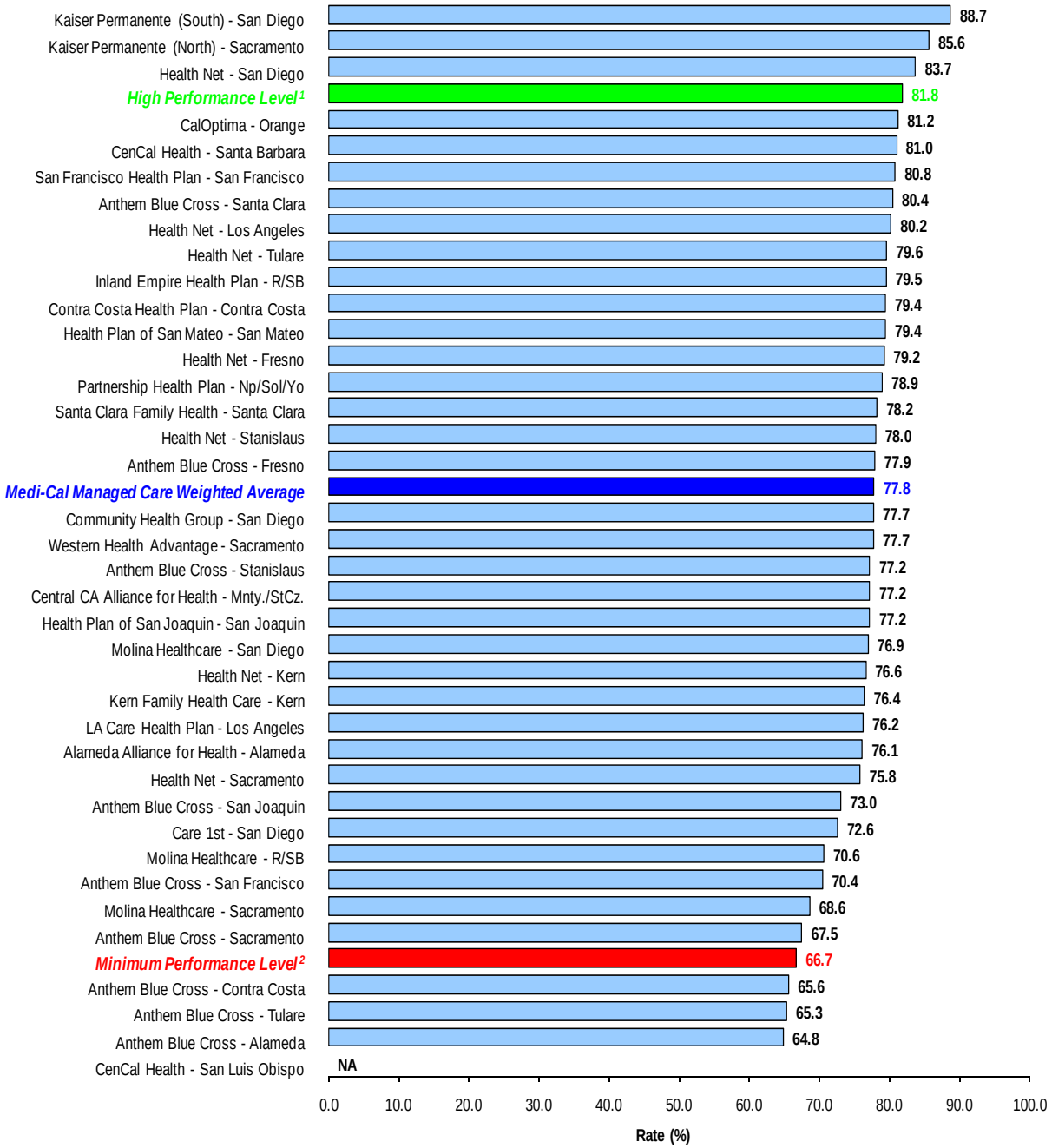
[29] American Diabetes Association. http://www.diabetes.org/heart-disease-stroke.jsp. Accessed October 5, 2009.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Comprehensive Diabetes Care - LDL-C Screening



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average showed no change between 2008 and 2009. The program's weighted average performed above the national Medicaid average from 2006 to 2008 and below the national commercial average for the same time period.

High and Low Performers

Three plans performed above the HPL—Kaiser Permanente's North (Sacramento County) and South (San Diego County) plans and Health Net—San Diego County—while three plans fell below the MPL: Anthem Blue Cross' plans for Contra Costa, Tulare, and Alameda counties.

Three plans had statistically significant increases, and two plans had statistically significant decreases, demonstrating relatively stable performance among plans for this measure.

Performance by model type was also similar, with the COHS model type slightly outperforming the GMC and Two-Plan model types. The COHS model type also exceeded the MCMC weighted average.

Comprehensive Diabetes Care—LDL-C Control

Measure Definition

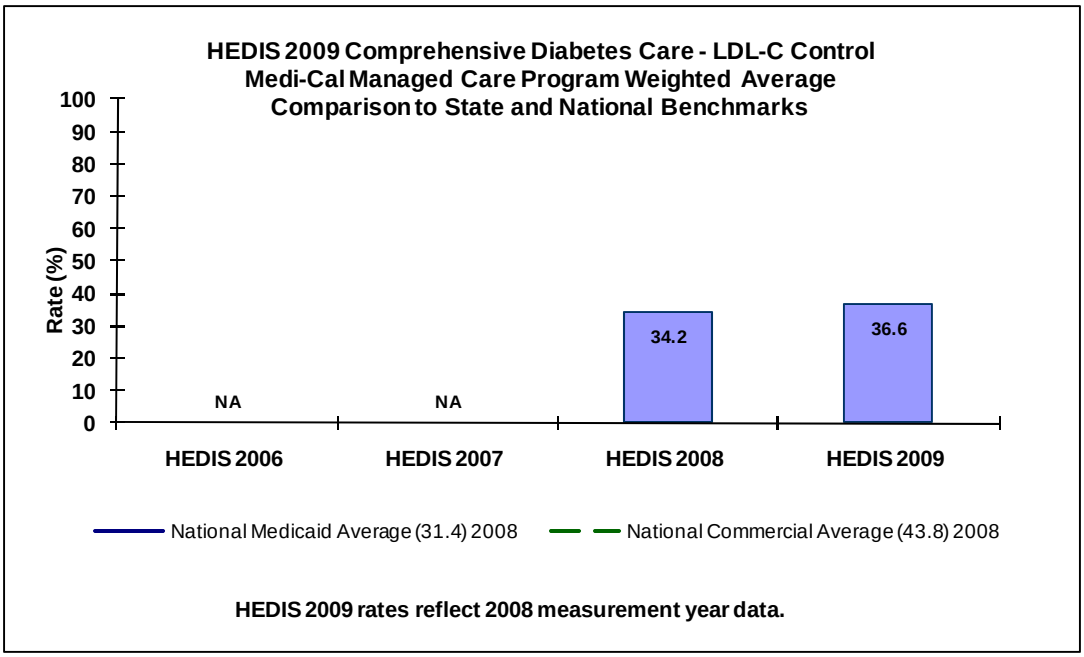
The *Comprehensive Diabetes Care—LDL-C Control* measure calculates the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) whose most recent LDL-C test (performed during the last two years) indicated an LDL-C level of less than 100 mg/dL.

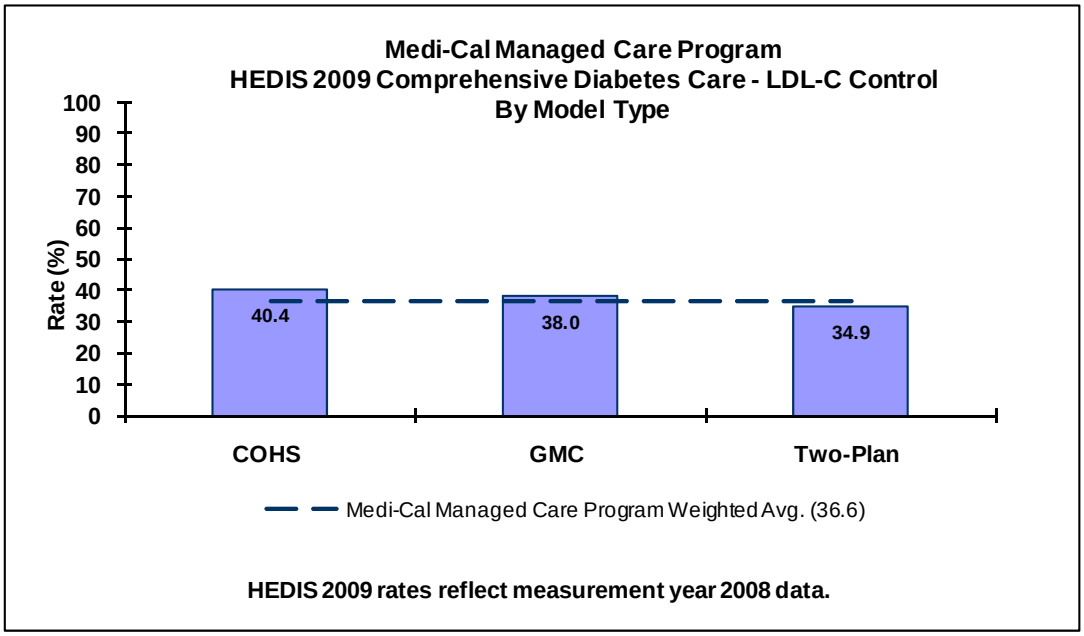
Importance

According to the American Diabetes Association, a desirable LDL-C is less than 100 mg/dL.[30] Early detection and treatment of LDL levels in individuals with diabetes can decrease their risk of cardiovascular complications.

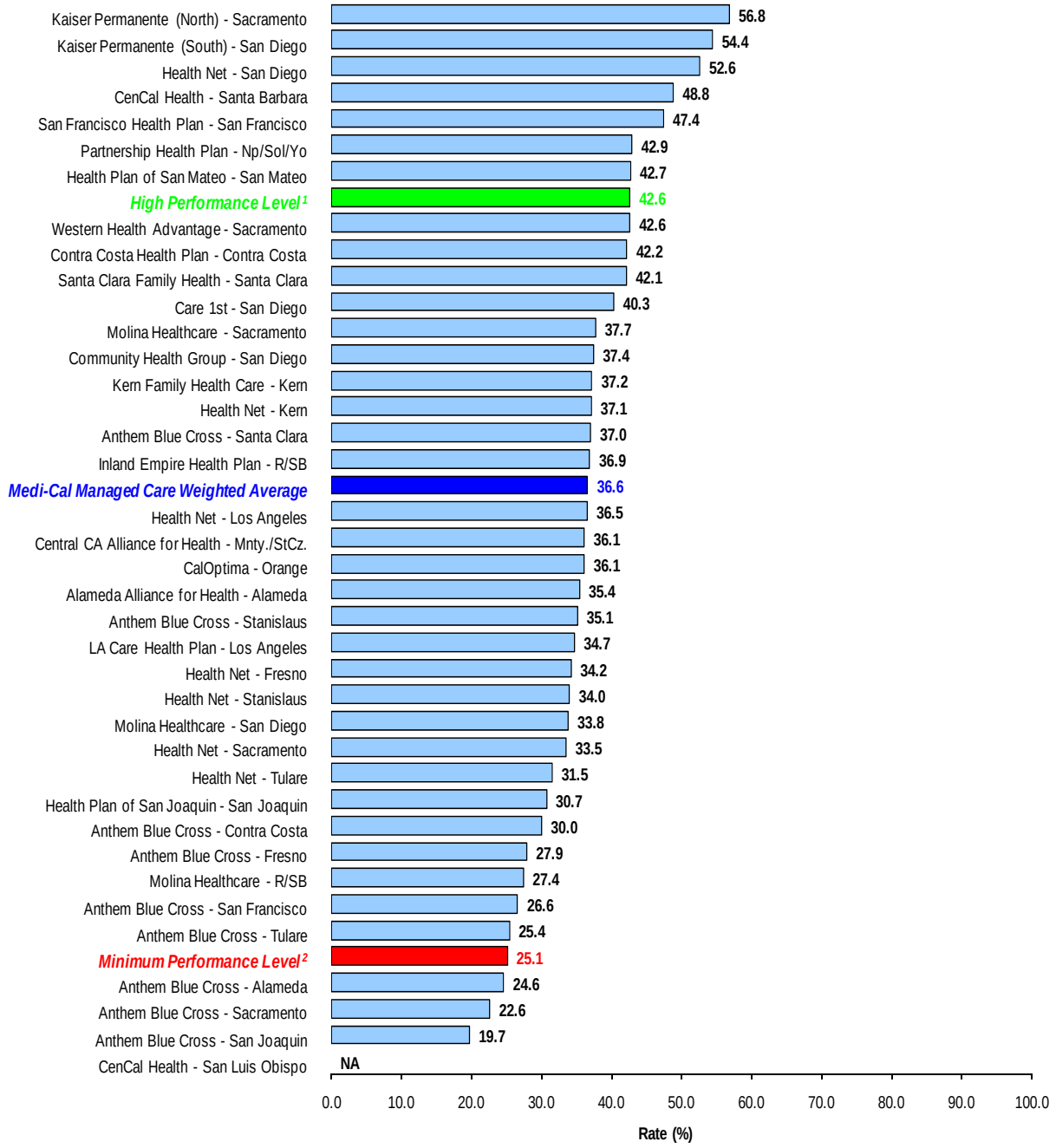
[30] American Diabetes Association. http://www.diabetes.org/heart-disease-stroke.jsp. Accessed October 5, 2009.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Comprehensive Diabetes Care - LDL-C Control



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average showed an increase in 2009 compared with 2008 that was not statistically significant. In 2008, the MCMC Program performed above the national Medicaid average but below the national commercial average.

The program demonstrated better performance compared to the national Medicaid average for 2008, but performance was worse compared to the national commercial average. The DHCS added this measure beginning in 2008, so no rates for comparison to prior years were available.

High and Low Performers

Seven plans performed above the established HPL while only three plans fell below the MPL, signifying good performance for a second-year measure.

Eight plans had statistically significant increases, and only two plans had statistically significant decreases in rates from 2008 to 2009.

The COHS model type outperformed the GMC and Two-Plan model types. Both the COHS and GMC model types exceeded the 2009 MCMC weighted average.

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

Measure Definition

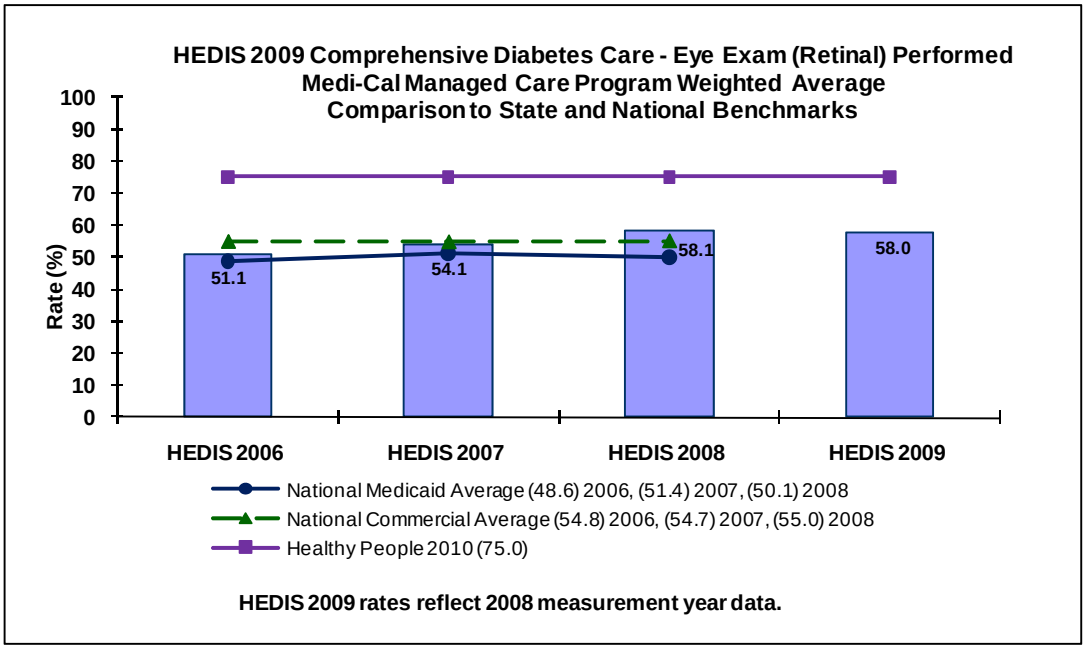
The *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who had an eye screening for diabetic retinal diseases (i.e., a retinal exam by an eye care professional).

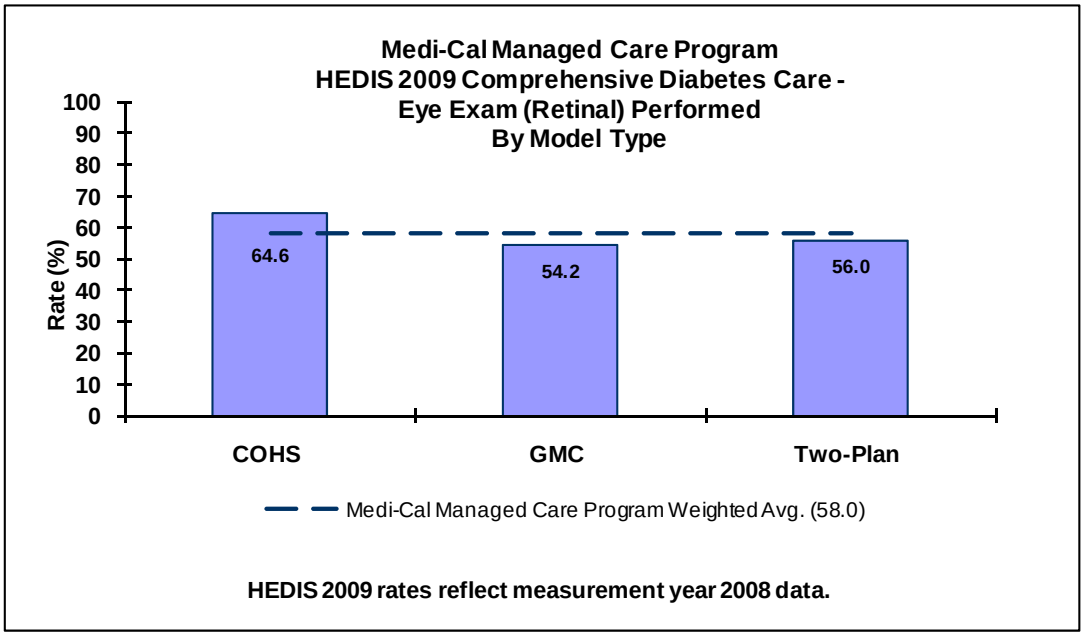
Importance

Diabetic retinopathy (abnormalities of the small blood vessels of the retina caused by diabetes) causes 12,000 to 24,000 new cases of blindness each year and is the leading cause of new cases of blindness in adults 20 to 74 years of age.[31] Up to 21 percent of Type 2 diabetics have retinopathy when they are first diagnosed with diabetes, and most will eventually develop some degree of retinopathy.[32] However, with timely and appropriate intervention—which may include laser treatment and vitrectomy—blindness can be reduced by up to 90 percent in patients with severe diabetic retinopathy.[33]

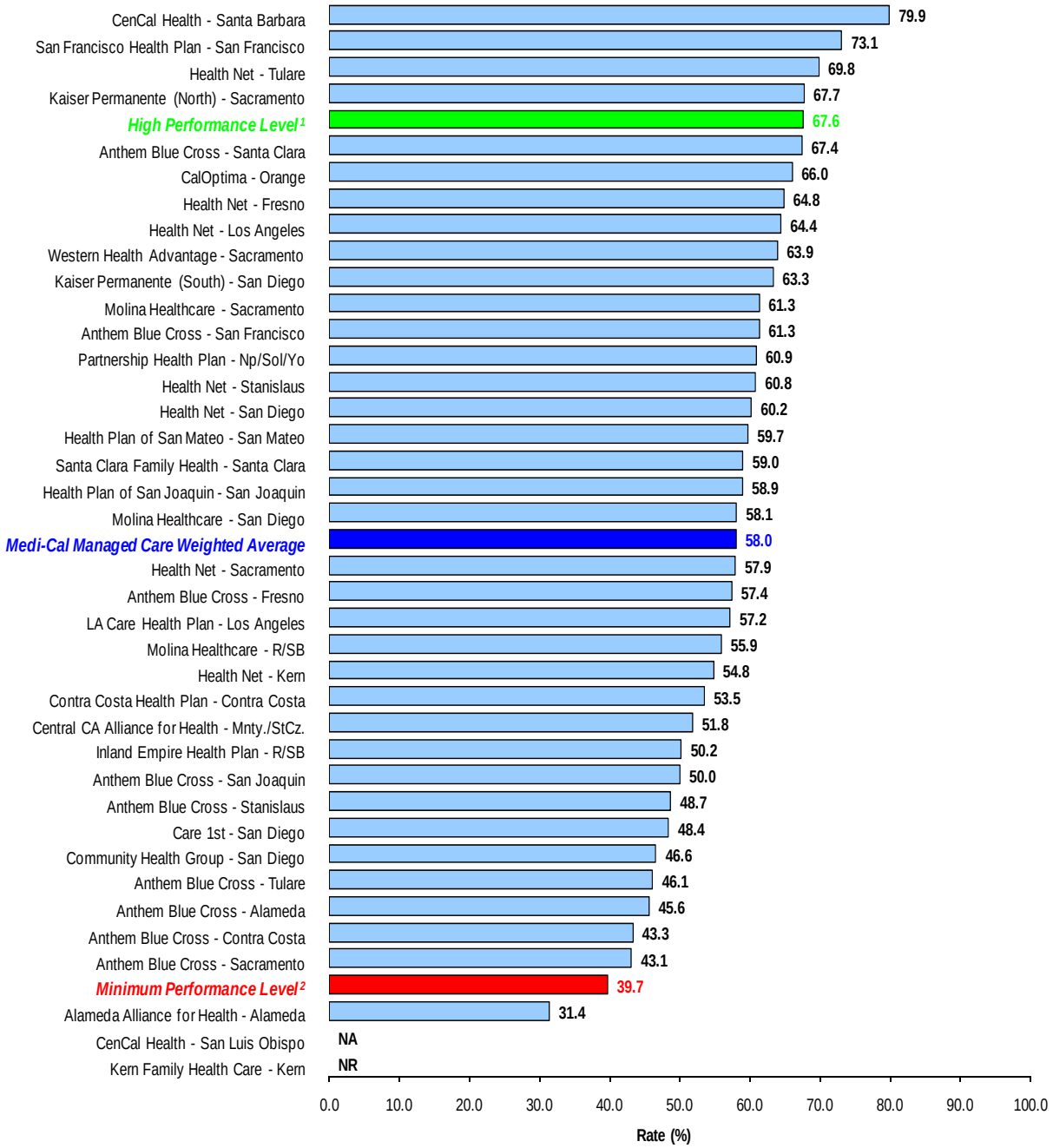
[31] American Diabetes Association. Diabetes and Retinopathy (Eye Complications). Available at: http://www.diabetes.org/diabetes-statistics/eye-complications.jsp. Accessed July 13, 2009.
[32] Ibid.
[33] National Institutes of Health. Fact Sheet: Diabetic Retinopathy. Available at: http://www.nih.gov/about/researchresultsforthepublic/DiabeticRetinopathy.pdf. Accessed July 13, 2009.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Comprehensive Diabetes Care - Eye Exam (Retinal) Performed



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average remained essentially unchanged in 2009 compared to its 2008 rate. The program's performance since 1996 has remained above the national Medicaid average, and for 2008, performance exceeded the national commercial average. Nonetheless, the program's rates were well below the Healthy People 2010 goal.

High and Low Performers

Four plans performed above the established HPL while only one plan, Alameda Alliance for Health—Alameda County, fell below the MPL. CenCal Health—Santa Barbara County achieved a 79.9 percent rate in 2009, consistent with its performance in 2008, exceeding all benchmarks.

Five plans had statistically significant increases while three plans had statistically significant decreases in rates from 2008 to 2009.

The COHS model type outperformed the GMC and Two-Plan model types and exceeded the MCMC 2009 weighted average.

Comprehensive Diabetes Care—Medical Attention for Nephropathy

Measure Definition

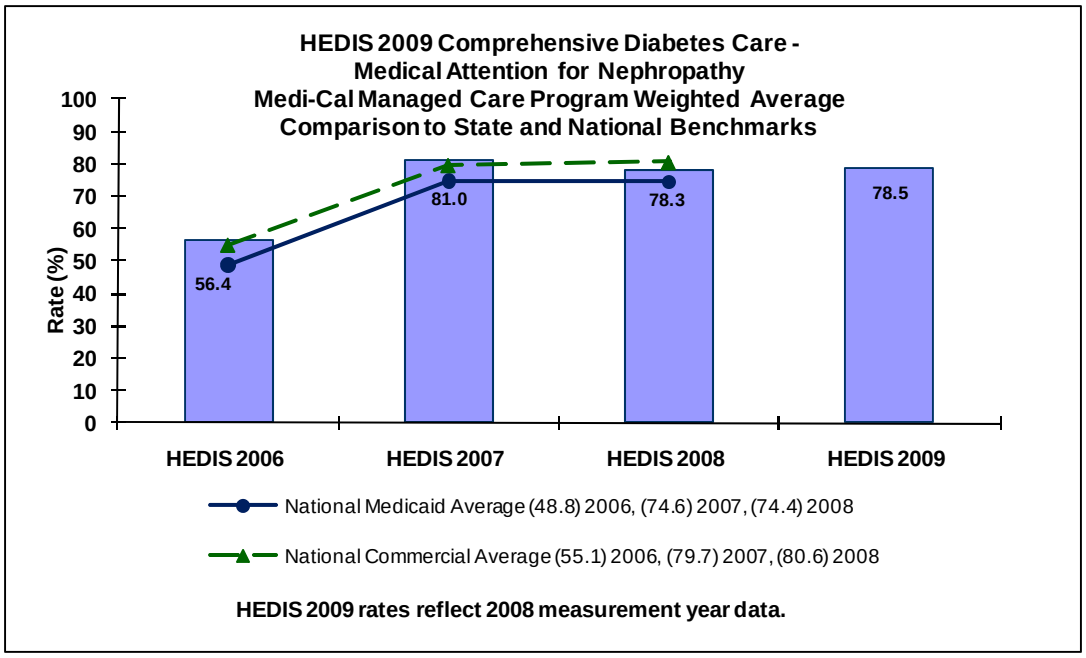
The *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy* measure assesses whether diabetic patients are being monitored for nephropathy (kidney disease). It reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who were screened for nephropathy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

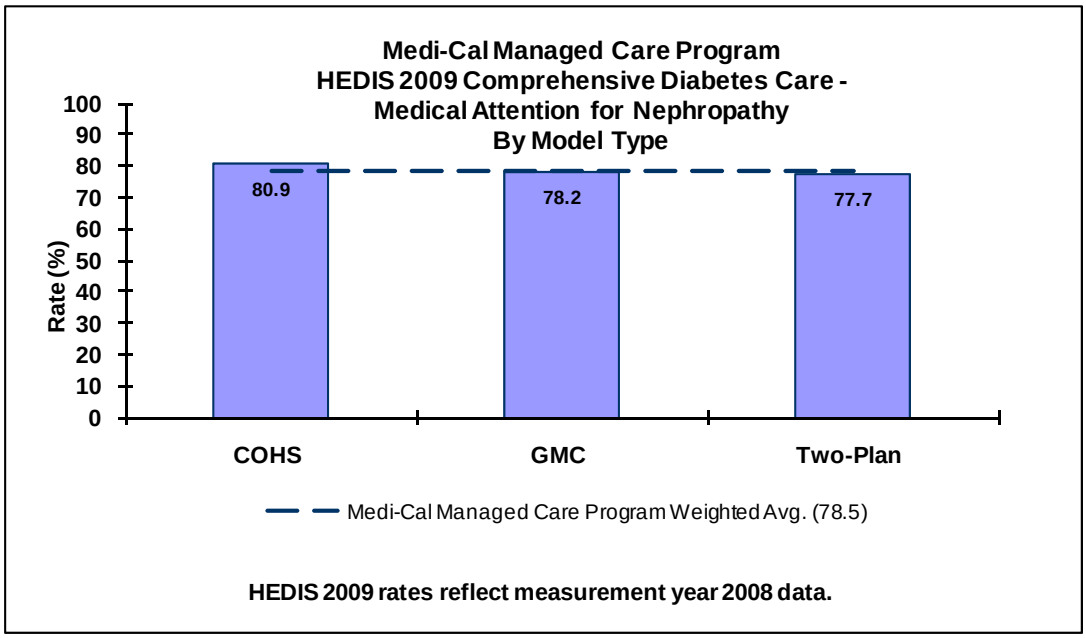
Importance

Diabetes is the leading cause of end-stage renal disease, a condition that can be treated only by dialysis or a kidney transplant. In the United States almost 180,000 people live with kidney failure as a result of diabetes. In 2005, health care for patients with kidney failure cost the United States about $32 billion.[34] Diabetic nephropathy is a progressive kidney disease that takes years to develop and progress. Usually 15 to 25 years will pass after the onset of diabetes before kidney failure occurs.

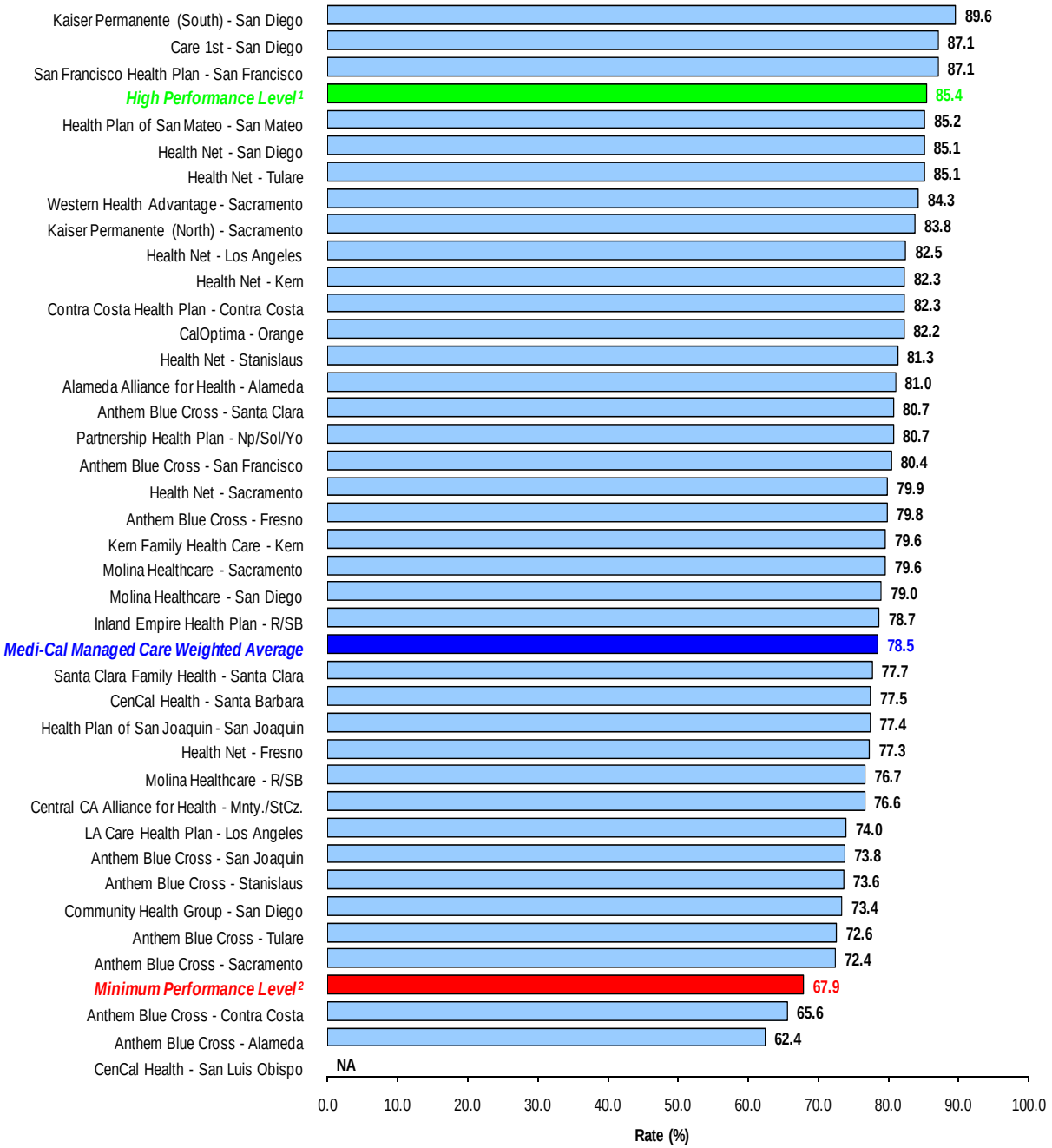
[34] National Kidney and Urologic Diseases Information Clearinghouse. Kidney Disease of Diabetes. Available at: http://kidney.niddk.nih.gov/kudiseases/pubs/kdd/index.htm. Accessed July 13, 2009.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Comprehensive Diabetes Care - Medical Attention for Nephropathy



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average was stable in 2009 compared to 2008. Since 2006 the program's weighted average has remained above the national Medicaid average and just below the national commercial average, falling below the national commercial average for the first time in 2008.

High and Low Performers

Three plans exceeded the HPL, and only two plans fell below the MPL. In 2008, four plans achieved the HPL, and four plans fell below the MPL.

Eight plans had statistically significant increases while four plans had statistically significant decreases in rates from 2008 to 2009.

The COHS model type performed better than the GMC and Two-Plan model types.

Comprehensive Diabetes Care—Best Practices

The MCMC plans have implemented several successful interventions to improve *Comprehensive Diabetes Care* HEDIS rates. For the purposes of this report, success is defined as achieving sustained improvement over three or more years. Plans' QIPs focusing on diabetes care have been effective in improving HEDIS rates corresponding to the *Comprehensive Diabetes Care* measures for *Eye Exam (Retinal) Performed, Hemoglobin A1c (HbA1c) Testing* and *LDL-C Screening*. The following QIP interventions have contributed to plans' sustained HEDIS rate improvement on the *Comprehensive Diabetes Care* HEDIS measure indicators:[35]

- Implementation of a diabetic disease management program
- Elimination of benefit referral requirements for diabetic members' annual eye exam
- Identification of diabetic members in a new member welcome call assessment
- Distribution of health report cards to members with their testing and results history
- Use of member incentives for compliance with all screening requirements
- Distribution of quarterly newsletters with diabetes articles and updates
- Contact with noncompliant members using reminder letters/calls
- Use of report cards to providers documenting their care of diabetic members, including identification of diabetic members, a summary of all diabetes services received, and a chart tool
- Recognition of top-performing practitioners in diabetes care
- Distribution of monthly newsletters to practitioners

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

Interventions related to education, either for the member or practitioner, were more successful if plans repeated them numerous times and distributed educational materials using varied modalities.

In addition, the Community Guide documents sufficient evidence to support systems-level interventions for disease management, case management, and diabetes self-management education as effective population-based interventions.[36]

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 their health plan in the first trimester or within 42 days of enrollment in the health plan.

Importance

More than 4 million infants are born in the United States each year. Approximately 520,000 of these infants are born preterm, and another 338,000 are of low birth weight.[37] Low birth weight increases the risk for neurodevelopmental handicaps, congenital abnormalities, and respiratory illness compared to infants with a normal birth weight.

With comprehensive prenatal care, the incidence of low birth weight and infant mortality can be reduced. Mothers who do not receive prenatal care are up to four times more likely to experience fatal complications related to pregnancy than those who receive prenatal care.[38] Additionally, women who receive timely, adequate prenatal care may be more likely to maintain a healthy weight and avoid extended hospitalization after giving birth.[39]

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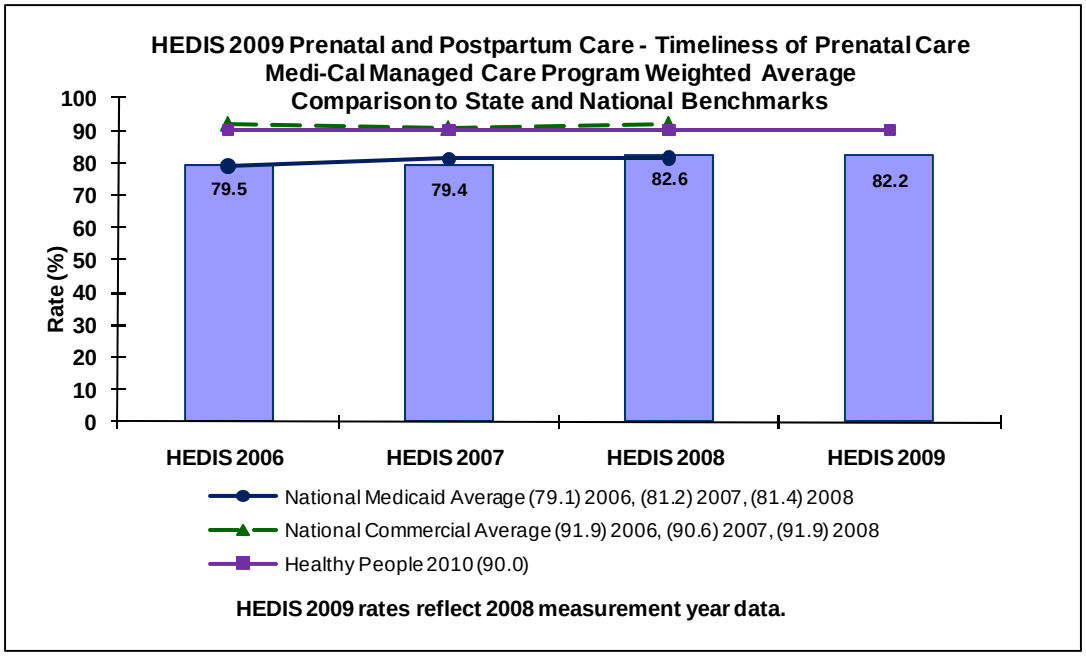
[36] Diabetes. Guide to Community Preventive Services Web site. Centers for Disease Control and Prevention. www.thecommunityguide.org/diabetes/. Last updated:06/14/2005. Accessed October 6, 2009.

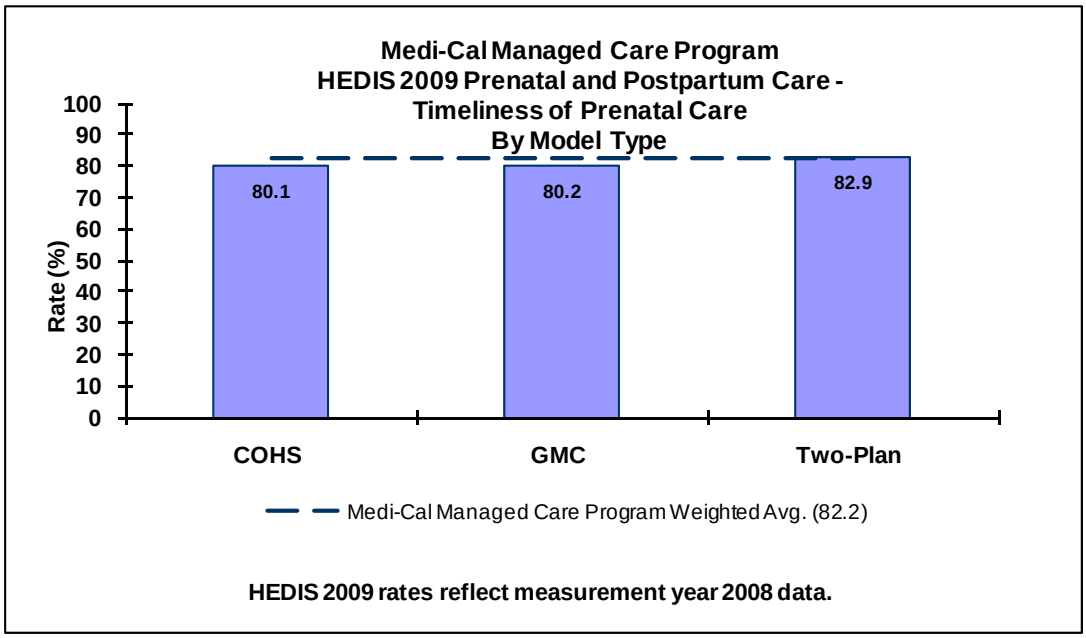
[37] National Committee for Quality Assurance. The State of Health Care Quality 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed September 1, 2009.

[38] Ibid.

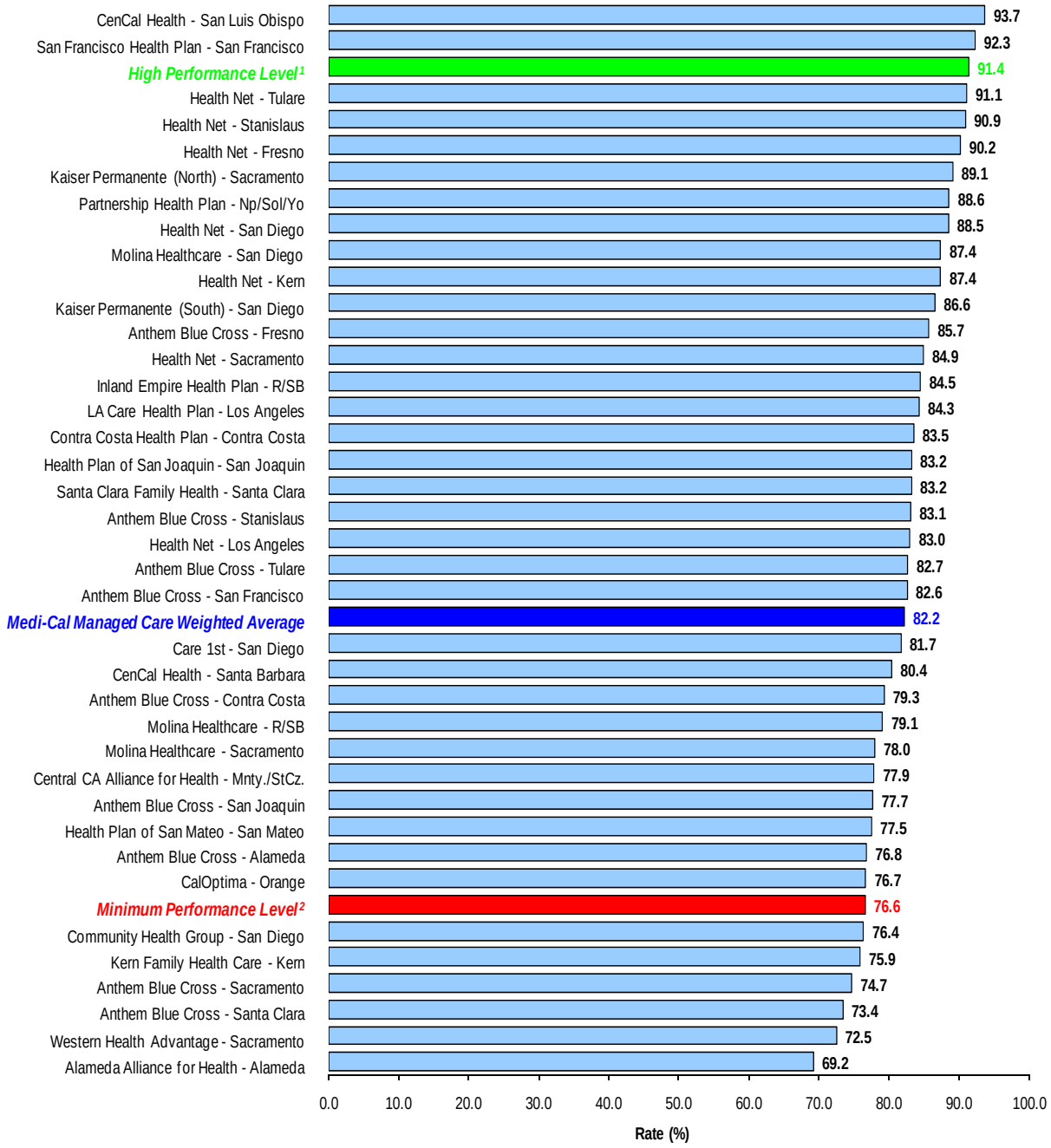
[39] National Committee for Quality Assurance. The State of Health Care Quality 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed July 10, 2009.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Prenatal and Postpartum Care -
Timeliness of Prenatal Care



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average decreased slightly from the 2008 rate. Since 2006 the MCMC Program's weighted average has been consistent with the national Medicaid average but has remained below the national commercial average and the Healthy People 2010 goal.

High and Low Performers

Despite this measure being part of the DHCS's auto-assignment program, only two plans, CenCal Health—San Luis Obispo County and San Francisco Health Plan—San Francisco County, performed above the HPL. Six plans fell below the MPL. Three plans, Alameda Alliance for Health—Alameda County, Community Health Group—San Diego County, and Western Health Advantage—Sacramento County, performed below the MPL in 2008 and 2009.

Three plans demonstrated statistically significant improvement over their 2008 rates: Anthem Blue Cross—Alameda County, Central California Alliance for Health—Monterey/Santa Cruz counties, and San Francisco Health Plan—San Francisco County. Six plans had a statistically significant decrease in their 2009 rate compared to their 2008 rate. These plans included: Anthem Blue Cross—Sacramento County, Anthem Blue Cross—Santa Clara County, Anthem Blue Cross—Tulare County, CalOptima—Orange County, CenCal Health—Santa Barbara County, and Molina Healthcare—Riverside/San Bernardino counties.

The Two-Plan model outperformed both the COHS and GMC model types and exceeded the MCMC 2009 weighted average.

Best Practices

The MCMC plans initiated several QIP interventions that demonstrated sustained improvement for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* HEDIS measure.[40] The interventions included systems interventions to facilitate the administrative capture of prenatal visits. Effective client interventions included the following:

- Bus tokens or taxi vouchers for transportation
- Incentives for timely prenatal visits
- Member contact regarding missed appointments
- Priority scheduling of late-entry prenatal patients
- Mailings to members of childbearing age with information on women's health, including prenatal care

[40] Health Services Advisory Group. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 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 received a postpartum visit on or between 21 days and 56 days after delivery.

Importance

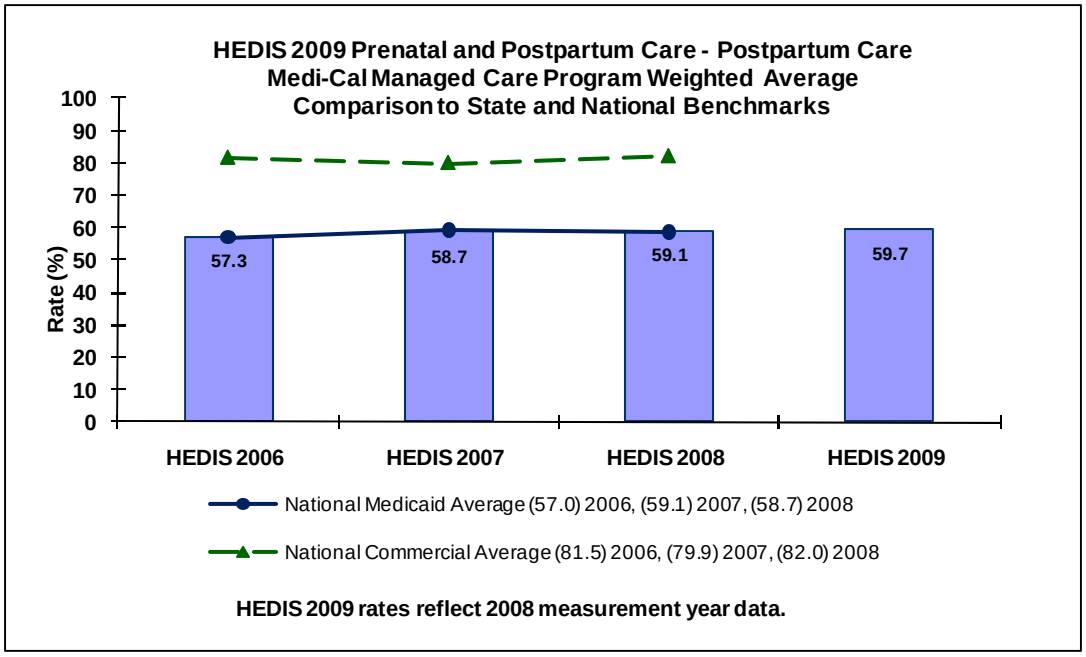
While care strategies tend to emphasize the prenatal period, appropriate care during the postpartum period can also prevent complications and deaths. For example, more than 60 percent of maternal deaths occur during the postpartum period.[41]

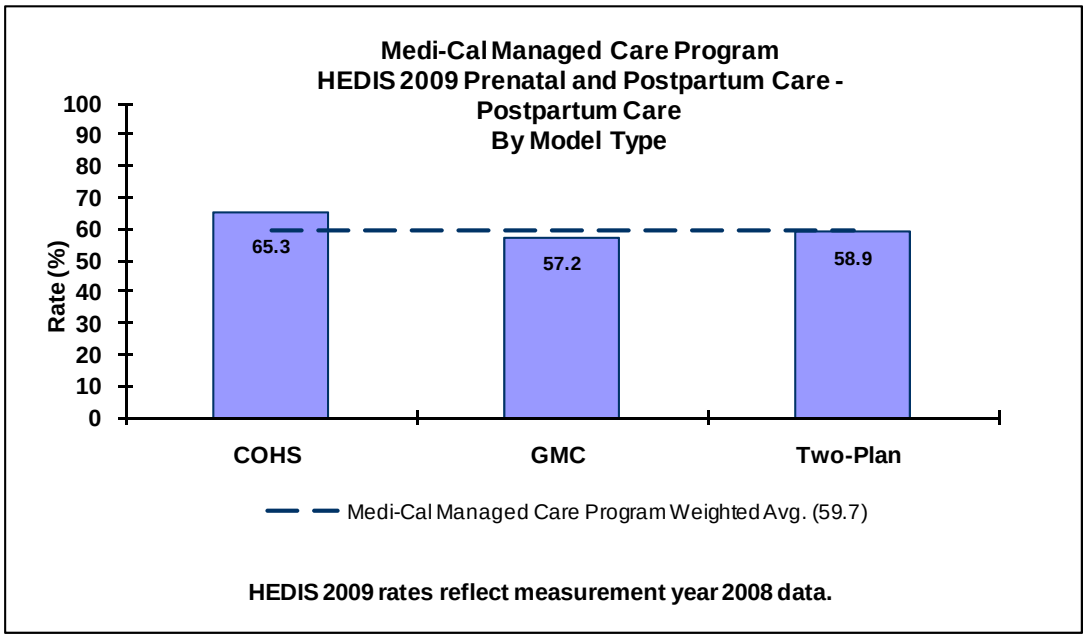
The American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists recommend that women who give birth have a postpartum care visit four to six weeks after delivery. This visit provides important opportunities to assess the physical and psychosocial well-being of the mother, counsel her on infant care and family planning, and detect and give appropriate referrals for existing or developing chronic conditions such as diabetes, hypertension, or obesity.[42]

[41] Family Health International. Better Postpartum Care Saves Lives. Available at: http://www.fhi.org/en/RH/Pubs/Network/v17_4/postpartum.htm. Accessed July 10, 2009.

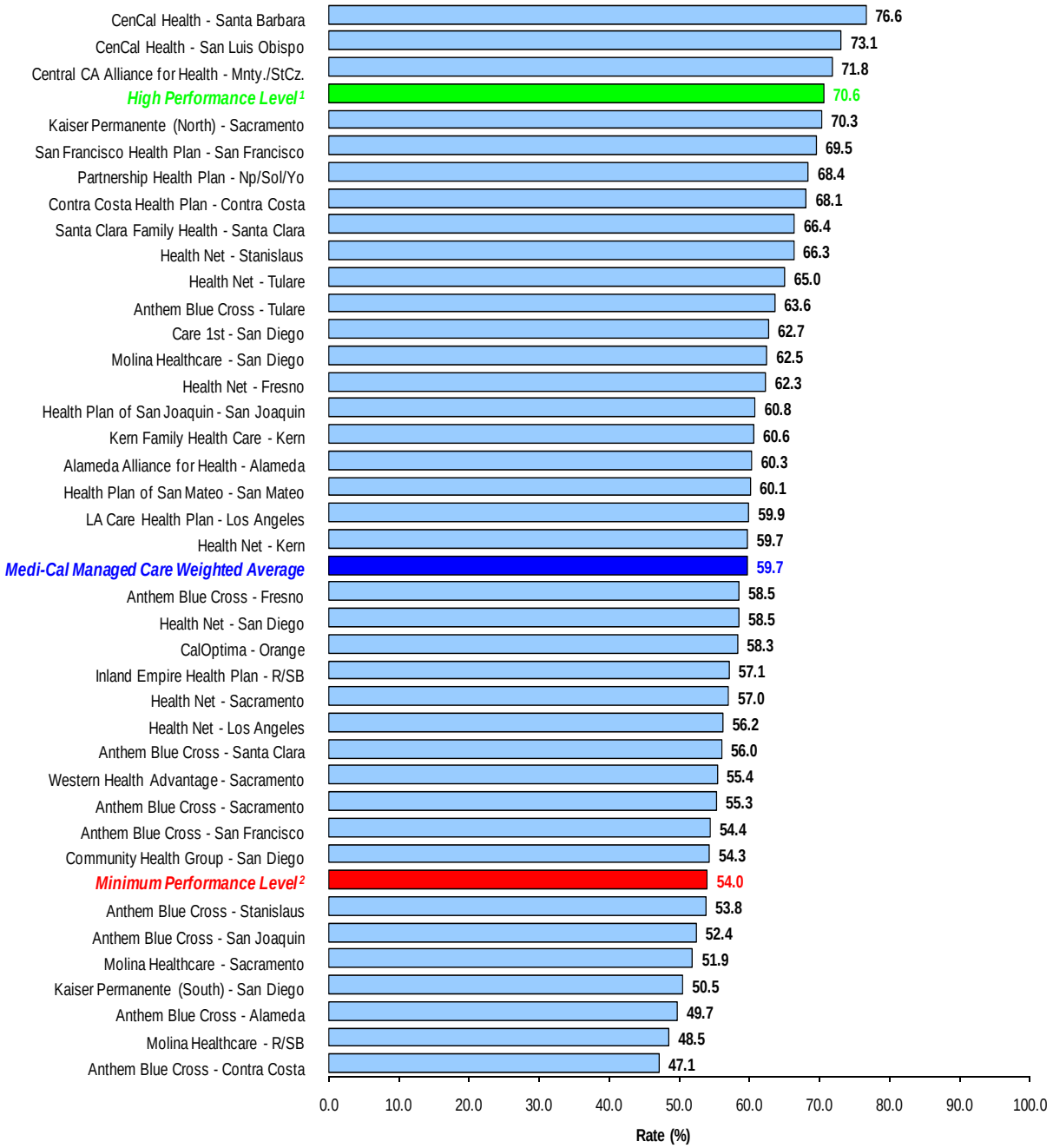
[42] American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care, 6th ed. Washington, DC: American College of Obstetricians and Gynecologists; 2007.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Prenatal and Postpartum Care - Postpartum Care



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average increased from 2008 to 2009. The increase was not statistically significant. The MCMC Program's weighted average has increased each year since 2006. During this time period the weighted average remained consistent with the national Medicaid average but well below the national commercial average.

High and Low Performers

Similar to the 2008 results, three plans achieved the established HPL in 2009. Central CA Alliance for Health—Monterey/Santa Cruz counties and CenCal Health—Santa Barbara County performed above the HPL in and 2008 and 2009. CenCal Health—San Luis Obispo County's rate also exceeded the HPL in 2009, which was the plan's first reporting year for this measure. Kaiser Permanente (North)—Sacramento County achieved the HPL in 2008 but just missed the 2009 HPL. Despite missing the HPL, this plan still demonstrated consistently high performance.

Seven plans ranked below the MPL in 2009, a decrease from 2008, when 12 plans fell below the MPL. Of these seven plans, six fell below the MPL in 2008, as well. Although some improvement in rates can be seen between 2008 and 2009, this measure remains an opportunity for improvement for many plans.

Four plans showed statistically different rates between 2008 and 2009. Contra Costa Health Plan—Contra Costa County and Molina Healthcare—San Diego County had statistically significant improvements in their rates, while Anthem Blue Cross—Fresno County and CalOptima—Orange County showed statistically significant declines in performance.

The COHS model type performed better than the GMC and Two-Plan model type and well above the MCMC weighted average.

Best Practices

QIPs focused on postpartum care that demonstrated that sustained improvement included the following interventions:[43]

- Bus tokens or taxi vouchers for transportation
- Member incentives for timely postpartum visits
- Postpartum appointments scheduled at 36 weeks gestation, with appointments falling within four to eight weeks after delivery
- An obstetrics tracking database to identify patients post-delivery who did not attend a postpartum visit, with member contact to facilitate an appointment
- Inclusion of a postpartum appointment as part of the hospital discharge plan

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

Use of Appropriate Medications for People With Asthma

Measure Definition

This measure evaluates whether members 5 to 56 years of age who have persistent asthma are prescribed medications acceptable as primary therapy for long-term control of asthma during the year.

Importance

In 2006, asthma accounted for more than 10.6 million visits to office-based physicians. Additionally, 444,000 hospital discharges occurred with asthma as the first-listed diagnosis.[44] Asthma is one of the most common chronic conditions in U.S. children and adults, affecting almost 7 million children and 16 million adults in 2007.[45]

According to the American Lung Association, asthma can be a life-threatening condition if it is not managed appropriately.[46] Controlling asthma as a chronic condition can reduce symptoms, decrease visits to the doctor and hospital emergency room, decrease missed days from work and school, and improve health outcomes. The use of appropriate medications for people with asthma provides a primary therapy for long-term control.[47]

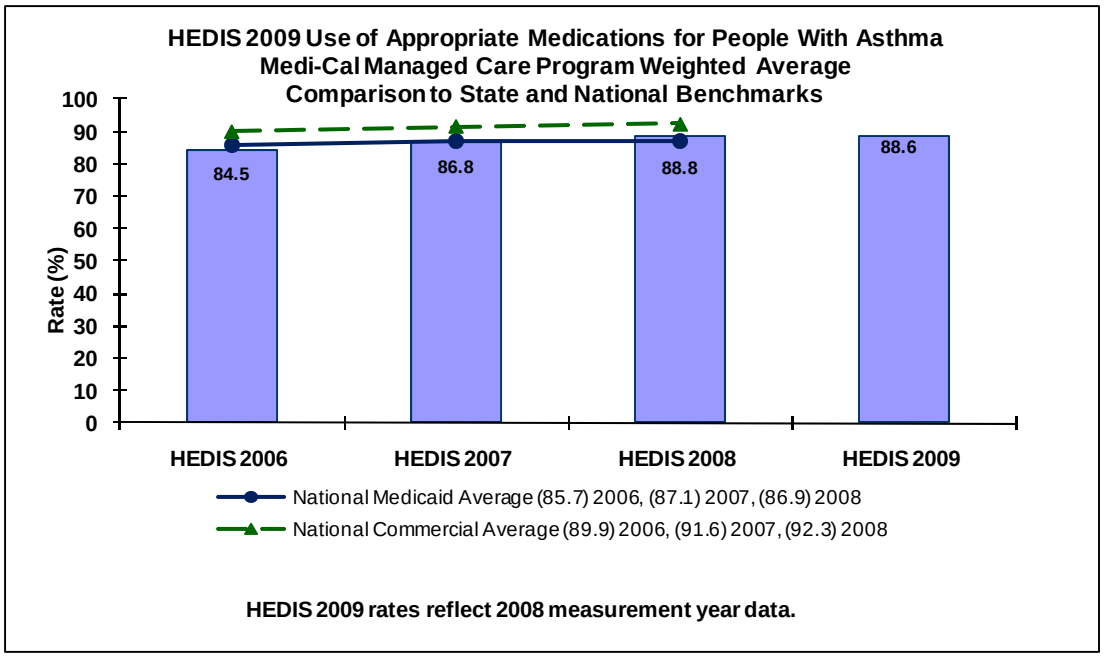
[44] Centers for Disease Control and Prevention. FastStats: Asthma. Available at: http://www.cdc.gov/nchs/FASTATS/asthma.htm. Accessed September 1, 2009.

[45] Ibid.

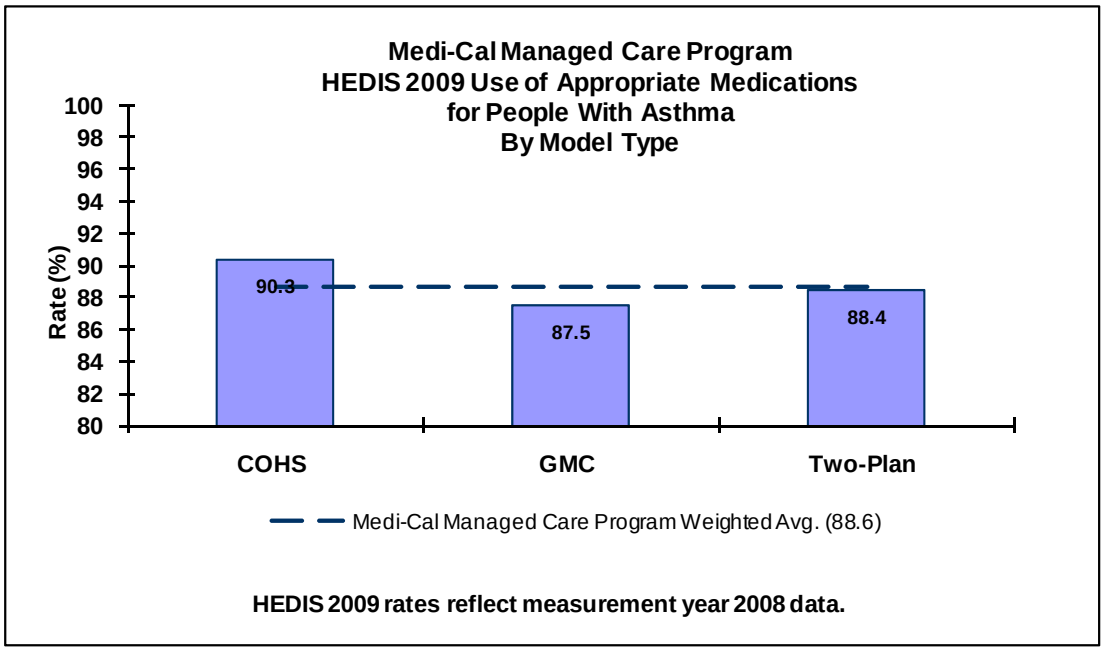
[46] The American Lung Association. Available at: http://www.lungusa.org/site/c.dvLUK9O0E/b.33276/k.D288/Asthma.htm. Accessed October 6, 2009.

[47] National Committee for Quality Assurance. Use of Appropriate Medications for People With Asthma, Technical Considerations. HEDIS 2000, Volume 2.

Performance Results

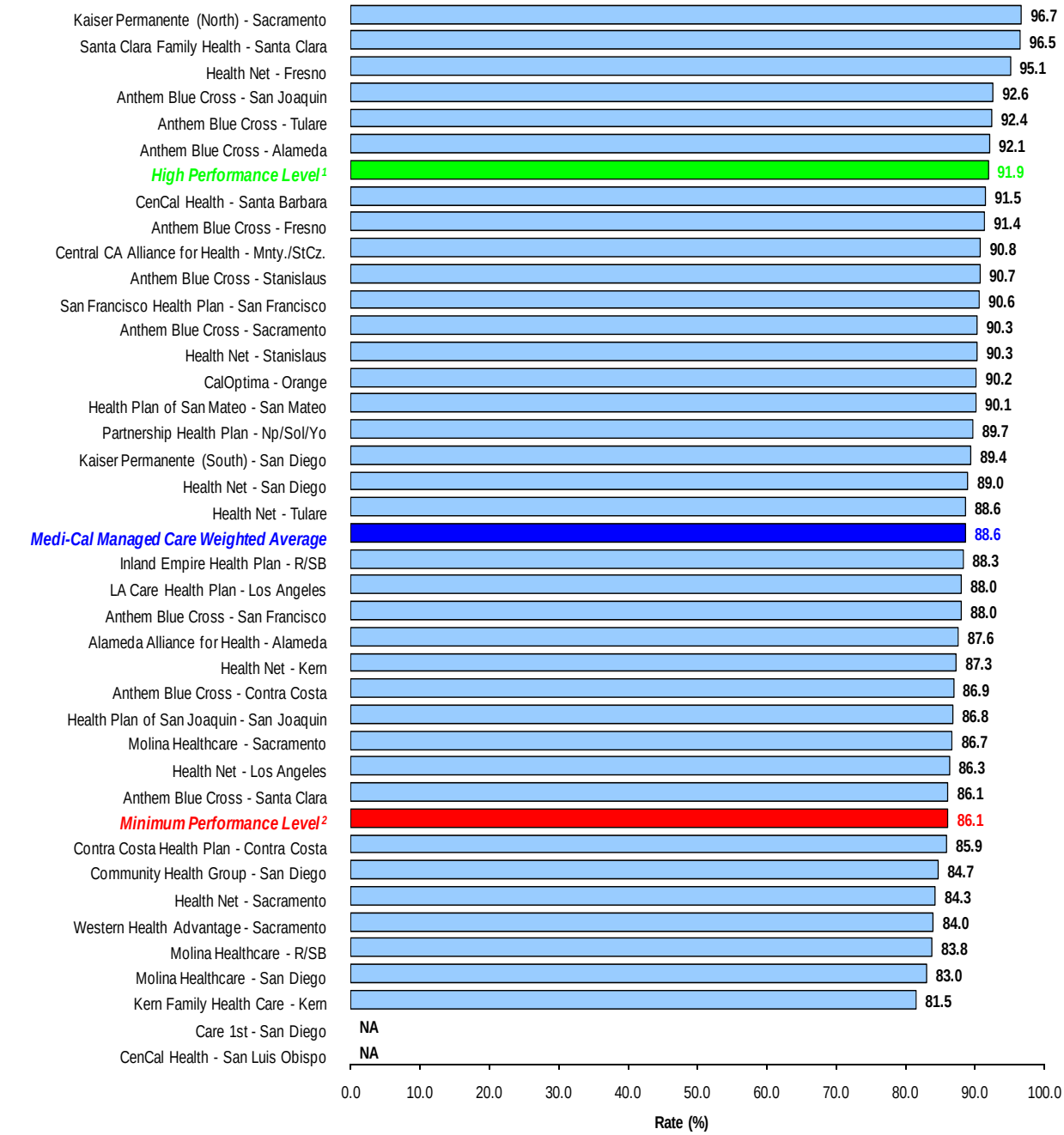


HEDIS 2009 rates reflect 2008 measurement year data.



HEDIS 2009 rates reflect measurement year 2008 data.

Medi-Cal Managed Care
HEDIS 2009 Use of Appropriate Medications for People With Asthma



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average showed minimal change in 2009 from its 2008 rate. The MCMC Program's performance has remained steady since 2006. The weighted average was consistent with the national Medicaid average but below the national commercial average. Because of the sustained overall MCMC performance and the high 2009 weighted average rate of 88.6 percent, the DHCS is discontinuing this measure from its EAS for 2010, allowing plans to shift resources to address alternative performance measures. The DHCS expressed its intent to collect plan rates for this measure at selected intervals to ensure that plans sustain performance.

High and Low Performers

Six plans performed above the HPL of 91.9 percent, and seven plans fell below the MPL of 86.1 percent, with the lowest plan score at 81.5 percent.

Three plans showed statistically significant improvement over their 2008 rate while two plans had a statistically significant decrease.

Best Practices

A wide range of health care factors can affect the HEDIS measure, *Appropriate Medications for People With Asthma*, including patient-provider relationships, medication compliance, chronic disease management, and disease self-management.

The Agency for Healthcare Research and Quality (AHRQ) developed the Asthma Return on Investment Calculator. It is an online, evidence-based tool to estimate the potential health care cost savings and productivity gains of an asthma quality improvement program for a health plan's Medicaid or commercial members.[48]

The Center for Healthcare Strategies, Inc. (CHCS), developed a toolkit for general asthma initiatives with approaches to improve asthma management.[49] This toolkit included recognizing common barriers faced by Medicaid plans in achieving better care for members with asthma, developing strategies to overcome these barriers, reviewing other health plans' strategies, and measuring incremental and long-term change.

[48] Agency for Healthcare Research and Quality. 2009. Available at http://statesnapshots.ahrq.gov/asthma/. Assessed September 3, 2009.

[49] Center for Healthcare Strategies, Inc. 2002. Achieving better care for asthma: a BCAP toolkit. Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=585903. Assessed September 3, 2009.

CHCS also developed a specific toolkit related to improving asthma management in children.[50] Innovative techniques included the following:

- Developing and creatively using asthma registries
- Using innovative methods to reach high-risk members
- Offering provider education on member self-management and appropriate prescribing
- Implementing provider incentives to reward high-quality asthma care

Several states included supplemental resources in the toolkit, such as asthma registry features, an in-home asthma trigger checkup, progress notes, action plan/cards, and a provider profiling letter.[51]

Well-Child Visits in the First 15 Months of Life

Measure Definition

The *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure calculates the percentage of members 15 months of age who receive six or more visits with a PCP during their first 15 months of life.

Importance

The AMA and AAP recommend timely, comprehensive well-child visits for children. In 2004, 85 percent of children younger than 6 years of age received a well-child checkup during the previous year.[52] These periodic checkups allow clinicians to assess a child's physical, behavioral, and developmental status, and to provide any necessary treatment, intervention, or referral to a specialist. A study of Medicaid children who were up to date with AAP's recommended well-child visit schedule showed a significant reduction in risk of avoidable hospitalizations for that group.[53]

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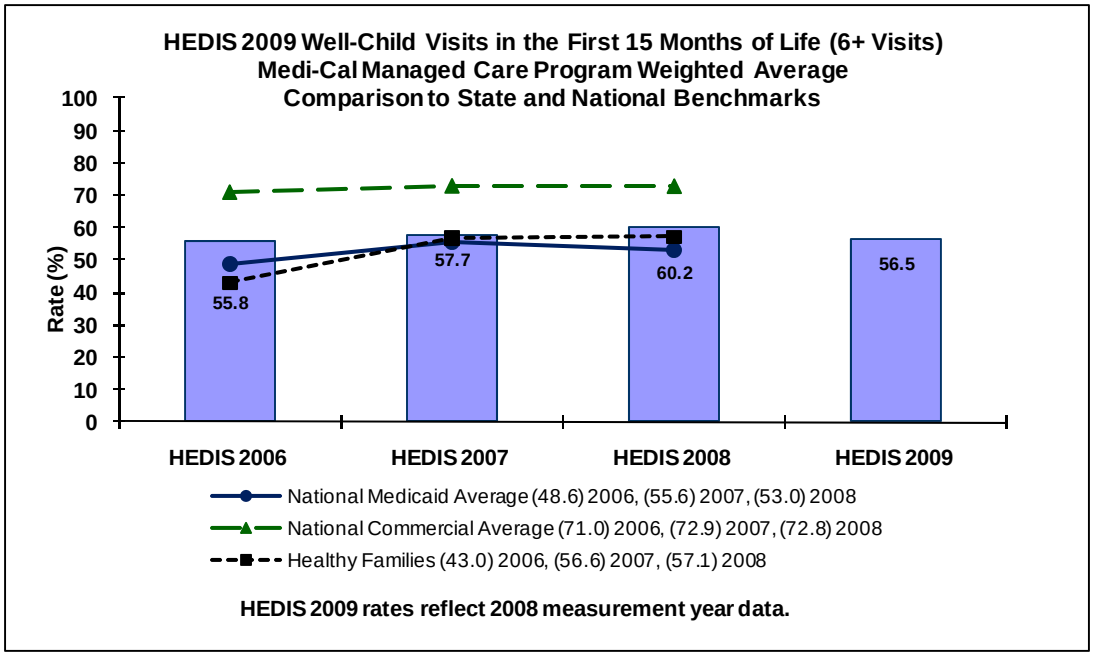
[50] Center for Healthcare Strategies, Inc. 2006. Improving asthma care for children: Best practices in Medicaid managed care—A BCAP toolkit. Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=384761 Accessed September 3, 2009.

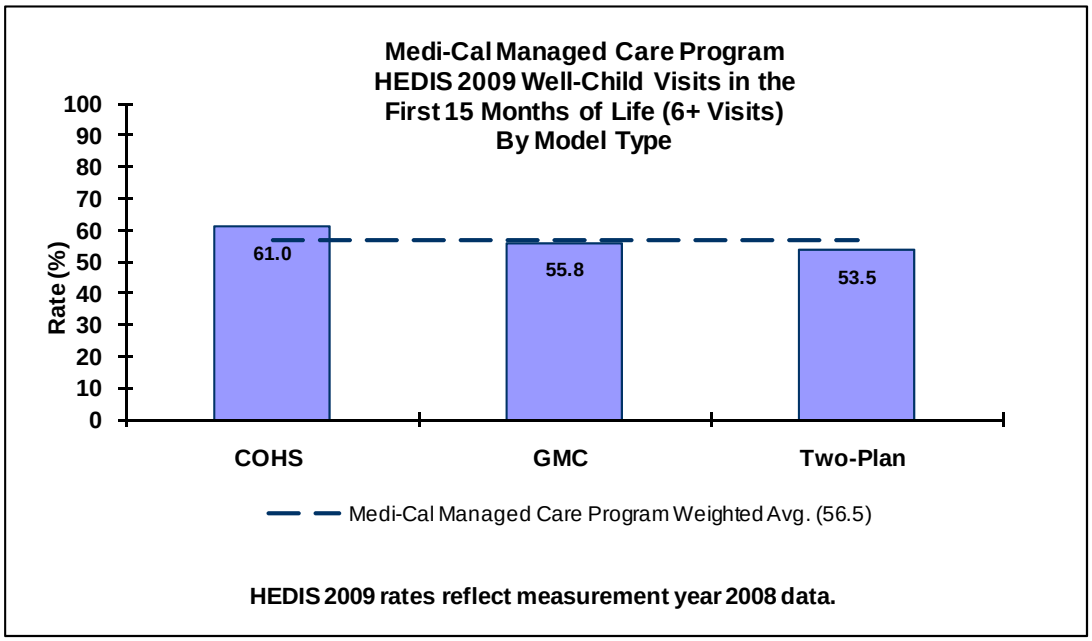
[51] Center for Healthcare Strategies, Inc. 2006. Resources from the toolkit: Improving asthma care for children: Best practices in Medicaid managed care—A BCAP toolkit. Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=208926. Accessed September 3, 2009.

[52] Child Trends Databank. *Well-child visits*. Available at: http://www.childtrendsdatabank.org/indicators/93WellChildVisits.cfm. Accessed July 7, 2006.

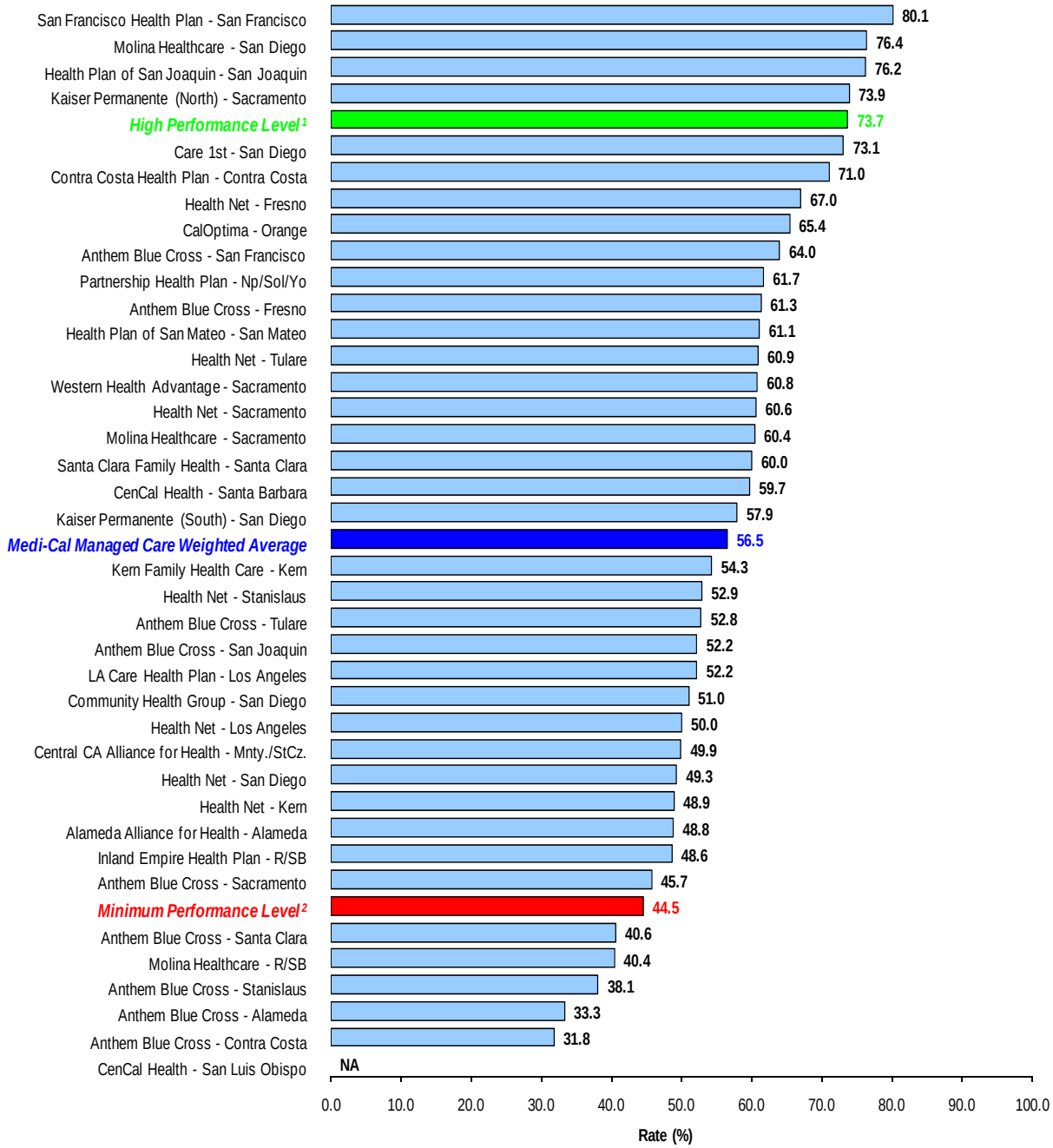
[53] Hakim, RB, Bye, BV. Effectiveness of Compliance With Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries. *Pediatrics*. 2001, 108 (1): 90-97.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Well-Child Visits in the First 15 Months of Life (6+ Visits)



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile.
[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average showed a decrease for 2009 compared with 2008, although the decrease was not statistically significant. From 2006 to 2008 the MCMC Program's weighted average performed above the national Medicaid average and below the national commercial average for the same time period.

High and Low Performers

Four plans performed above the HPL, and five plans fell below the MPL. In 2008 three plans achieved the HPL, and eight plans fell below the MPL.

Beginning in 2010 the DHCS will eliminate the requirement for plans to report this measure as part of its external accountability and will select another hybrid measure for plan reporting.

Four plans showed statistically significant improvement over their 2008 rates, while six plans had a statistically significant decrease.

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

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

Measure Definition

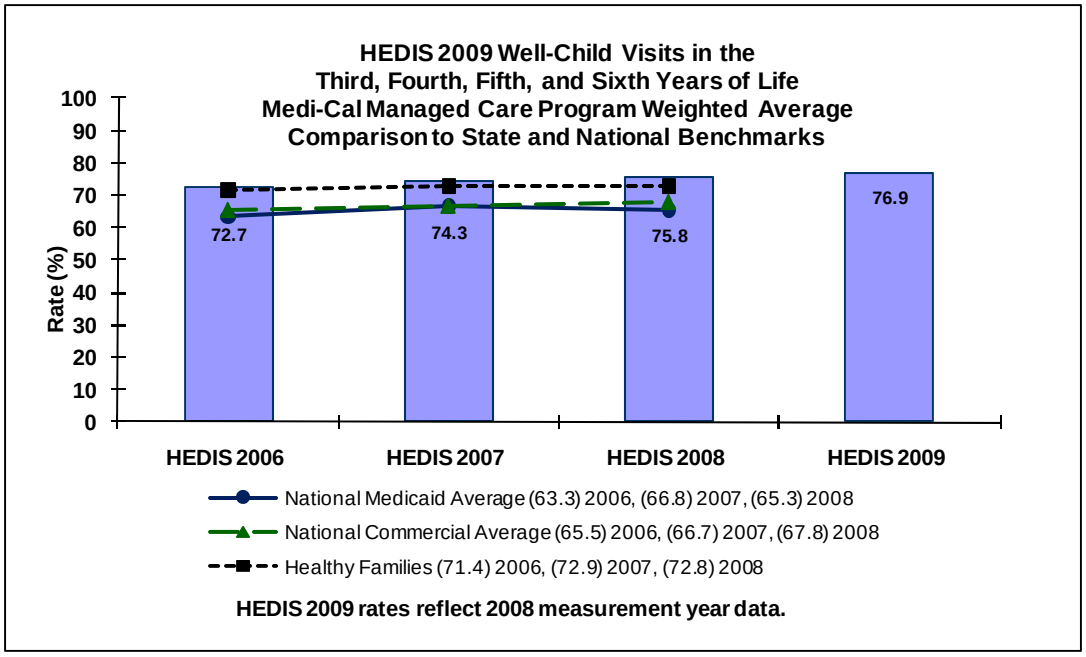
The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure reports the percentage of members 3, 4, 5, or 6 years of age who received one or more well-child visits with a PCP within the prior year.

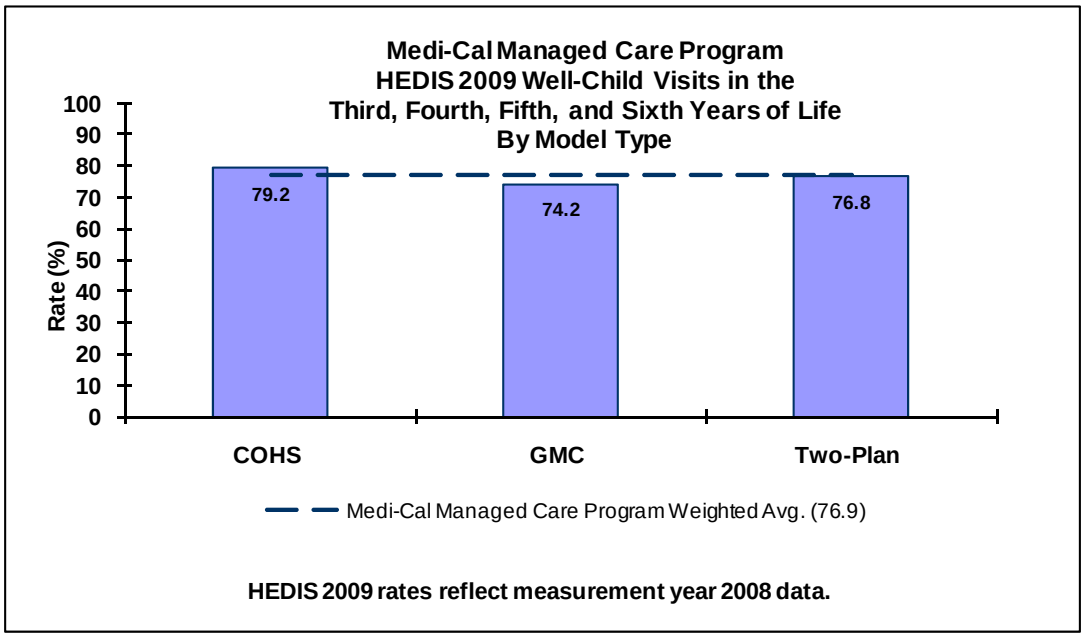
Importance

The AAP recommends annual well-child visits for children between 2 and 6 years of age.[54] These checkups during the preschool and early school years help clinicians to detect vision, speech, and hearing problems as early as possible. Early intervention in these areas can improve a child's communication skills and reduce language and learning problems.

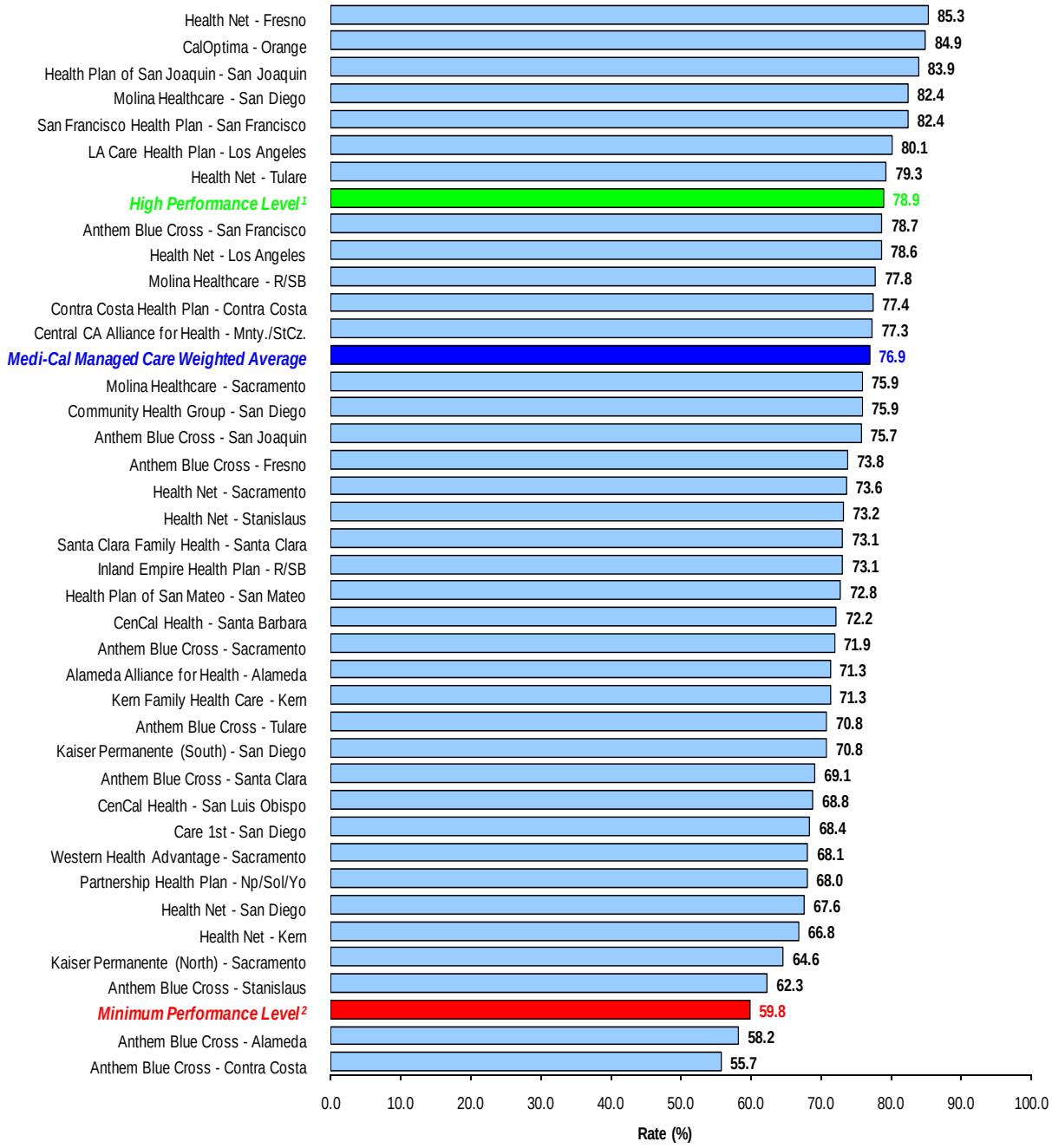
[54] American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. Available at: http://practice.aap.org/content.aspx?aid=1599. Accessed August 17, 2007.

Performance Results





Medi-Cal Managed Care
HEDIS 2009 Well-Child Visits in the
Third, Fourth, Fifth, and Sixth Years of Life



[1] High Performance Level is HEDIS 2008 national Medicaid 90th Percentile

[2] Minimum Performance Level is HEDIS 2008 national Medicaid 25th Percentile.

Note: HEDIS 2009 rates reflect 2008 measurement year data.

Summary of Results

The MCMC Program's weighted average increased in 2009 compared with 2008. Since 2006 the MCMC Program's weighted average gradually improved, performing above both the national Medicaid and commercial averages.

High and Low Performers

Seven plans exceeded the established HPL, and only two plans reported rates below the MPL in 2009, a reduction from 2008, when five plans reported rates below the MPL. This measure was part of the DHCS's auto-assignment program, which may have contributed to the consistent performance among plans.

Three plans showed statistically significant improvement over their 2008 rates. Two of these three plans, Western Health Advantage—Sacramento County and Kaiser Permanente (South)—San Diego County, fell below the MPL in 2008 but increased their rates in 2009 to rank above the established MPL in 2009. In addition, Contra Costa Health Plan—Contra Costa County increased its rate above the MCMC weighted average in 2009. In 2008 Contra Costa County's rate ranked just above the MPL.

Five plans showed statistically significant decreases in performance in 2009 compared with their 2008 rates: Health Net—Kern County and the Anthem Blue Cross plans in Alameda, Fresno, San Francisco, and Tulare counties.

Well-Child Visits Best Practices

Plans have implemented several successful interventions to increase well-child visits. Successful in this context means a plan achieved sustained improvement of at least two years over the baseline year. The most effective interventions are those that target specific barriers and target both members and providers.

Culturally appropriate materials such as reminders and newsletters have been associated with real improvement among member-targeted interventions.

Provider interventions included provider-specific feedback on well-child visit rates and encounter/claims data review for missed opportunities such as performing well-child assessments during sick visits. By implementing electronic tracking tools and provider prompts, plans can increase well-child visit rates.

QIPs that use a state-mandated topic and collaborative QIPs conducted by all contracted health plans are among the most effective methods for improving statewide rates.[55]

A stepped-intervention approach aimed at improving immunization rates was effective in improving well-child visits.[56] The steps included first mailing reminders to members, followed by phone calls to nonresponders (which involved several attempts to contact), followed by case management and/or visits to those who were still noncompliant.

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

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

The HEDIS *Ambulatory Care (AMB)* measure falls under the HEDIS Use of Services measures and summarizes utilization in the following areas:

- Outpatient Visits—Office visits, other outpatient visits, and home visits
- Emergency Department (ED) Visits—Visits to the emergency room that did not result in an inpatient admission
- Ambulatory Surgery Procedures—Surgeries and procedures in an outpatient hospital setting or in free-standing surgical centers
- Observation Room Stays—Observation room stays that did not result in an inpatient admission

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

Beginning in 2010, the DHCS will remove these measures from the EAS, requiring plans to report these rates internally and analyze performance as part of their ongoing quality assurance process.

Table 6.1––HEDIS 2009 Medi-Cal Managed Care Ambulatory Care Measure*

	Health Plan and County	Outpatient Visits	ED Visits	Ambulatory Surgery Procedures	Observation Room Stays
	Alameda Alliance for Health—Alameda	134.2	27.2	7.4	0.2
	Anthem Blue Cross—Alameda	177.8	60.4	8.3	0.3
	Anthem Blue Cross—Contra Costa	150.4	56.0	5.6	0.1
	Anthem Blue Cross—Fresno	309.1	41.0	6.4	0.1
	Anthem Blue Cross—Sacramento	238.7	36.1	5.4	0.1
	Anthem Blue Cross—San Francisco	241.2	32.2	7.9	0.3
	Anthem Blue Cross—San Joaquin	264.4	38.7	6.1	0.1
	Anthem Blue Cross—Santa Clara	224.4	34.6	5.0	0.1
	Anthem Blue Cross—Stanislaus	286.1	56.0	4.2	0.1
	Anthem Blue Cross—Tulare	351.8	41.8	4.5	0.1
	CalOptima—Orange	342.6	37.1	4.5	1.1
	Care 1st—San Diego	183.9	39.3	3.0	0.2
	CenCal Health—San Luis Obispo	577.4	64.9	9.5	1.1
	CenCal Health—Santa Barbara	460.1	48.9	8.7	1.2

* Measures are per 1,000 member months.

Table 6.1––HEDIS 2009 Medi-Cal Managed Care Ambulatory Care Measure*

Health Plan and County	Outpatient Visits	ED Visits	Ambulatory Surgery Procedures	Observation Room Stays
Central CA Alliance for Health—Mnty./StCz.	324.0	62.1	8.1	13.8
Community Health Group—San Diego	255.8	27.0	4.3	0.1
Contra Costa Health Plan—Contra Costa	304.7	57.1	11.8	0.1
Health Net—Fresno	395.0	39.2	4.0	0.2
Health Net—Kern	317.2	41.5	5.9	0.2
Health Net—Los Angeles	250.3	29.0	2.6	0.3
Health Net—Sacramento	233.4	26.4	4.1	0.1
Health Net—San Diego	298.0	43.7	7.1	0.4
Health Net—Stanislaus	370.8	53.3	3.5	0.1
Health Net—Tulare	410.8	41.1	3.3	0.9
Health Plan of San Joaquin—San Joaquin	272.8	34.7	7.0	1.4
Health Plan of San Mateo—San Mateo	493.2	52.7	17.3	1.8
Inland Empire Health Plan—R/SB	255.0	48.0	5.1	0.5
Kaiser Permanente (North)—Sacramento	453.8	40.4	3.5	1.3
Kaiser Permanente (South)—San Diego	483.1	40.7	3.3	2.7
Kern Family Health Care—Kern	273.6	40.3	2.6	0.0
LA Care Health Plan—Los Angeles	226.0	33.2	1.1	0.4
Molina Healthcare—R/SB	178.0	39.9	2.7	0.3
Molina Healthcare—Sacramento	176.9	31.9	2.3	0.2
Molina Healthcare—San Diego	229.2	39.2	5.3	0.3
Partnership Health Plan—Np/Sol/Yo	294.6	46.1	9.2	0.9
San Francisco Health Plan—San Francisco	215.2	20.6	4.9	0.1
Santa Clara Family Health—Santa Clara	278.4	35.0	7.7	0.2
Western Health Advantage—Sacramento	233.6	30.2	11.7	0.0

* Measures are per 1,000 member months.

The DHCS held contracts with four specialty plans in 2009 that required these plans to report on two performance measures annually. This section includes results from the specialty plans' 2009 performance measures, which reflect data from January 1, 2008, to December 31, 2008. As each specialty plan provides unique services relevant to its population, HSAG includes local and national benchmarks as available.

AHF Healthcare Centers

AHF Healthcare Centers, previously referred to as both AIDS Healthcare Centers and Positive Healthcare, operates in Los Angeles County and primarily provides services to dual-eligible members enrolled in Medicare and the Medi-Cal Managed Care Program. AHF specializes in providing services to members living with HIV or AIDS.

AHF's performance measures were *Adults' Access to Preventive/Ambulatory Health Services* and *Colorectal Cancer Screening*.

Adults' Access to Preventive/Ambulatory Health Services

Measure Definition

The *Adults' Access to Preventive/Ambulatory Health Services* measure calculates the percentage of adults 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.

Importance

Access to appropriate and effective health care is an essential component of the effort to diagnose and treat health problems and to increase the quality and duration of healthy life. Establishing a relationship with a primary care practitioner is necessary to improve access to care for both adults and children. To increase access to quality care, the public health system, health plans, and health care researchers focus on identifying barriers to existing health services and eliminating disparities. Through this process, health plans can increase preventive care and successfully manage diseases.

Performance Results

Table 7.1—Adults' Access to Preventive/Ambulatory Health Services (AAP)

		20 – 44 years	45 – 64 years	65+ years
	Rate	**98.5%**	**95.6%**	**92.3%**
	HPL	87.6%	90.2%	93.5%
	MPL	71.6%	79.3%	74.6%

Summary of Results

AHF Healthcare exceeded the MPL for all reported age groups and exceeded the HPL for adults 20 to 64 years of age.

Colorectal Cancer Screening

Measure Definition

The *Colorectal Cancer Screening* measure calculates the percentage of adults 50 to 80 years of age who had appropriate screening for colorectal cancer.

Importance

The American Cancer Society estimates that colon cancer will be the third-leading cancer site for new cases diagnosed in 2009 and will account for an estimated 9 percent of all cancer-related deaths in the United States in 2009 for both men and women.[57]

Colon cancer screening can result in the detection and removal of colorectal polyps before they become cancerous, as well as detect cancer at an early stage. Colon cancer screening reduces death by decreasing the incidence of colorectal cancers and by detecting a higher proportion of cancers at early, more treatable stages.[58]

Performance Results

Table 7.2—HEDIS 2009 Rates for AHF Healthcare Centers

		Colorectal Cancer Screening*
	Rate	**55.6%**
	HPL	68.4%
	MPL	49.9%

*The MPL and HPL for this measure is the 2008 national commercial 25th and 90th percentile, respectively, since no Medicaid benchmark exists for this measure.

[57] American Cancer Society. *Cancer Facts & Figures 2009*. Atlanta: American Cancer Society; 2009.
[58] Ibid.

Summary of Results

AHF Healthcare performed above the MPL and below the HPL. The DHCS based the MPL and HPL on the 2008 national commercial 25th and 90th percentiles, respectively, since no Medicaid benchmark exists for this measure.

Family Mosaic Project

The Family Mosaic Project (FMP) is organized under the Child, Youth, and Family System of Care within the Community Behavioral Health Services program under the City and County of San Francisco—Department of Public Health.

The DHCS contracted with FMP as a specialty plan in February 1993 to provide approved Medi-Cal children and adolescents at risk for out-of-home placement in San Francisco County with intensive case management and wrap-around services through a capitation agreement.

In 2006 Medi-Cal, at the direction of CMS, designated FMP as a managed care plan that must comply with managed care external quality review requirements and other contract requirements for the DHCS to receive federal financial participation for FMP. The DHCS amended FMP's contract in early 2007 to include federal and State requirements for managed care plans. Among these requirements, the DHCS required that FMP report on two performance measures annually.

At the time HSAG began compliance audits for 2009 reporting, FMP did not have performance measures in place for reporting or validation. After extensive review, HSAG determined that FMP did not have standardized data available to support accurate performance measure reporting and found that FMP needed a considerable amount of technical assistance to develop performance measures. Due to the unique services FMP provides, standardized HEDIS measures were not appropriate. The plan needed FMP-specific performance measures.

In March 2009, HSAG began providing FMP with intensive technical assistance, which included an on-site information systems capability assessment in June 2009. Technical assistance to develop performance measures continued through October 2009, and HSAG finalized two performance measure definitions for which FMP will begin reporting rates in 2010. One performance measure calculates mental health inpatient admissions and the other calculates out-of-home placements.

Kaiser Prepaid Health Plan (PHP)

Kaiser PHP is a prepaid health plan that operates in Marin and Sonoma counties. Kaiser PHP provides medical services similar to full-scope plans, but the DHCS considers it a specialty plan based on its small population.

Kaiser PHP's performance measures were *Appropriate Testing for Children With Pharyngitis* and *Appropriate Treatment for Children With Upper Respiratory Infection.*

Appropriate Testing for Children With Pharyngitis

Measure Definition

The *Appropriate Testing for Children With Pharyngitis* measure reports the percentage of members 2 to 18 years of age who were diagnosed with pharyngitis, prescribed an antibiotic, and received a Group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Importance

Pharyngitis, an infection or irritation of the throat and/or tonsils (sore throat), occurs most commonly in children between 4 and 7 years of age.[59] Children in the United States experience an average of five sore throats per year and one streptococcal infection (strep throat) every four years.[60] An estimated 10 percent of all children who see a health care provider will be evaluated for pharyngitis.[61]

There are two types of pharyngitis: viral and bacterial. Determining the cause of the pharyngitis is vital to treatment, since antibiotics are ineffective against viral infections. Overuse of antibiotics can instead increase the number of drug-resistant forms of bacteria, which can be very difficult to treat. To diagnose a bacterial virus, such as Group A streptococcal pharyngitis (GABHS), appropriate laboratory tests should be used. Only 51 percent of physicians are performing the strep test on the pediatric population.[62] Strep throat caused by GABHS can be treated with antibiotics. Treatments for viral pharyngitis may include throat lozenges, increased fluid intake, and acetaminophen.[63]

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[59] eMedicine. Pharyngitis. Available at: http://www.emedicine.com/medscape.com. Accessed October 9, 2009.
[60] Ibid.
[61] National Committee for Quality Assurance. *The State of Managed Care Quality, 2006*. Standard Version. Washington, DC: National Committee for Quality Assurance: 2006.
[62] Ibid.
[63] Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/getsmart/antibiotic-use/sumptom-relief.html. Accessed October 13, 2009.

Table 7.3—HEDIS 2009 Rates for Kaiser PHP

		Appropriate Testing for Children With Pharyngitis
	Rate	**90.3%**
	HPL	77.3%
	MPL	47.9%

Summary of Results

Kaiser PHP performed above both the MPL and HPL in 2009.

Appropriate Treatment for Children With Upper Respiratory Infection

Measure Definition

The *Appropriate Treatment for Children With Upper Respiratory Infection* measure reports the percentage of members 3 months through 18 years of age who were diagnosed with a URI and who were not dispensed an antibiotic prescription.

Importance

Americans suffer from an estimated 1 billion URIs annually. Children have about three to eight URIs per year due to lack of exposure to prior infections and high contact with other children.[64] Although URIs are most often viral, antibiotics are frequently prescribed to children with this infection. When antibiotics are used inappropriately, an individual can develop a resistance to them over time, making the medication ineffective. Approximately $227 million is spent annually for inappropriate and unnecessary treatment of URIs.[65]

Performance Results

Table 7.4—HEDIS 2009 Rates for Kaiser PHP

		Appropriate Treatment for Children With Upper Respiratory Infection (URI)
	Rate	**97.5%**
	HPL	94.1%
	MPL	79.6%

Summary of Results

Kaiser PHP performed above both the MPL and HPL in 2009 with a rate of 97.5 percent. This plan did not report rates in 2008. Due to the exceptionally high performance and little opportunity for improvement, the plan and the DHCS may consider an alternative performance measure for future reporting.

[64] National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed July 9, 2009.
[65] Ibid

SCAN Health Plan

SCAN Health Plan provides medical services to members who are dual eligible for Medicare and Medi-Cal Managed Care. The plan operates in Los Angeles, San Bernardino, and Riverside counties.

Glaucoma Screening in Older Adults

Measure Definition

The *Glaucoma Screening in Older Adults* measure reports the percentage of members 65 years of age and older, without a prior diagnosis of glaucoma, who received an eye exam for glaucoma by an eye care professional.

Importance

Glaucoma is a group of diseases that result in irreversible damage to the optic nerve that carries information from the eye to the brain.[66] Glaucoma, if untreated, leads to blindness. According to the Agency for Healthcare Research and Quality, more than 2 million Americans older than 40 years of age have glaucoma, but many are unaware of it because vision loss is unnoticeable in the early stages of the disease. Screening for glaucoma is important for early detection and treatment to prevent and delay damage.

Table 7.5—HEDIS 2009 Rates for SCAN Health Plan

		Glaucoma Screening in Older Adults*
	Rate	**72.7%**
	HPL	77.3%
	MPL	50.7%

*The MPL and HPL for this measure is the 2008 national Medicare 25th and 90th percentile, respectively, since no Medicaid benchmark exists for this measure.

Summary of Results

SCAN Health Plan performed above the established MPL and under the HPL for this performance measure. The plan did not report rates in 2008.

[66] Agency for Healthcare Research and Quality. National Quality Measures Clearinghouse™. Available at: http://www.qualitymeasures.ahrq.gov/resources/faq.aspx. Accessed October 8, 2009.

Persistence of Beta-Blocker Treatment After a Heart Attack

Measure Definition

The *Persistence of Beta-Blocker Treatment After a Heart Attack* measure reports the percentage of members 18 years of age and older who were hospitalized and discharged with a diagnosis of acute myocardial infarction (heart attack) and who received persistent beta-blocker treatment for six months after discharge.

Importance

According to the Agency for Healthcare Research and Quality, almost 1 million new and recurrent heart attacks occur in the United States annually, resulting in 450,000 deaths.[67] The American Heart Association and the American College of Cardiology strongly recommend treatment using beta-blockers to reduce death during acute and long-term management of a heart attack.

Table 7.6—HEDIS 2009 Rates for SCAN Health Plan

		Persistence of Beta-Blocker Treatment After a Heart Attack
	Rate	**72.4%**
	HPL	82.1%
	MPL	50.0%

*The MPL and HPL for this measure is the 2008 national Medicare 25th and 90th percentile, respectively, since no Medicaid benchmark exists for this measure.

Summary of Results

SCAN Health Plan performed above the established MPL and under the HPL for this performance measure. The plan did not report rates in 2008.

[67] Agency for Healthcare Research and Quality. National Quality Measures Clearinghouse™. Available at: http://www.qualitymeasures.ahrq.gov/resources/faq.aspx. Accessed October 8, 2009.

Table A.1—National HEDIS 2008 Medicaid Percentiles

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Adolescent Well-Care Visits	27.2	35.9	42.1	51.4	56.7
Appropriate Treatment for Children With Upper Respiratory Infection	75.5	79.6	84.3	90.5	94.1
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	17.9	20.6	25.0	29.0	35.4
Breast Cancer Screening	38.8	44.4	50.1	56.4	61.2
Cervical Cancer Screening	50.5	56.5	67.0	72.4	77.5
Childhood Immunization Status—Combination 3	50.1	59.9	68.6	74.3	78.2
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	24.2	39.7	53.8	62.5	67.6
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)	15.9	27.7	32.8	38.9	42.5
*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)**	32.4	37.7	46.0	52.5	69.8
Comprehensive Diabetes Care—HbA1c Testing	65.7	74.2	79.6	85.6	88.8
Comprehensive Diabetes Care—LDL-C Control (< 100mg/dL)	16.5	25.1	33.1	37.9	42.6
Comprehensive Diabetes Care—LDL-C Screening	58.6	66.7	73.2	78.6	81.8
Comprehensive Diabetes Care—Medical Attention for Nephropathy	59.7	67.9	76.1	80.5	85.4
Prenatal and Postpartum Care—Postpartum Care	47.0	54.0	60.8	65.8	70.6
Prenatal and Postpartum Care—Timeliness of Prenatal Care	68.4	76.6	84.1	88.6	91.4
Use of Appropriate Medications for People With Asthma	80.4	86.1	88.7	90.6	91.9
Well-Child Visits in the First 15 Months—Six or More Visits	29.0	44.5	57.5	65.4	73.7
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	52.3	59.8	68.2	74.0	78.9

Source: NCQA. Medicaid HEDIS 2008 Audit Means, Percentiles and Ratios. Available at: http://www.ncqa.org/tabid/334/Default.aspx.

*For this measure, a lower rate indicates better performance.

Table B.1 provides three-year trending information for each plan across the reported measures. The following designations are provided within the table:

- - = A year that data was not collected.

NR = A *Not Report* audit designation. Also, the rate could not be publically reported due to material bias.

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

Within Table B.1 HSAG calculated statistical significance testing between the 2008 and 2009 rates for each measure using a χ test and displayed this information within the "2008–2009 Rate Difference" column. The following symbols are used to show statistically significant changes:

⇧= Rates in 2009 were significantly higher than they were in 2008.

⇩= Rates in 2009 were significantly lower than they were in 2008.

⇔= Rates in 2009 were not significantly different than they were in 2008.

Not comparable = A 2008–2009 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––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Alameda Alliance for Health—Alameda	*Adolescent Well-Care Visits*	40.6%	45.3%	44.8%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	93.6%	94.9%	90.6%	⇩
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	73.1%	25.9%	23.3%	⇔
	Breast Cancer Screening	55.5%	50.2%	45.2%	⇩
	Cervical Cancer Screening	77.4%	72.5%	69.6%	⇔
	Childhood Immunization Status—Combination 3	- -	70.6%	79.0%	⇧
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.3%	NR	31.4%	Not comparable
	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0%)***	- -	30.4%	23.2%	Not comparable

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Alameda Alliance for Health—Alameda (cont.)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)*	- -	48.9%	54.4%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	76.2%	73.5%	74.6%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	24.8%	35.4%	⇧
	Comprehensive Diabetes Care—LDL-C Screening	72.7%	71.3%	76.1%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.0%	74.2%	81.0%	⇧
	Prenatal and Postpartum Care—Postpartum Care	61.9%	57.7%	60.3%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	NR	74.0%	69.2%	⇔
	Use of Appropriate Medications for People With Asthma	90.3%	91.4%	87.6%	⇩
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	NR	53.5%	48.8%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NR	73.5%	71.3%	⇔
Anthem Blue Cross—Alameda	*Adolescent Well-Care Visits*	27.1%	34.0%	34.0%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	93.3%	93.4%	93.6%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	NA	36.9%	33.8%	⇔
	Breast Cancer Screening	42.7%	38.3%	41.1%	⇔
	Cervical Cancer Screening	63.9%	63.7%	60.0%	⇔
	Childhood Immunization Status—Combination 3	- -	52.5%	64.1%	⇧
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.7%	48.8%	45.6%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	20.2%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	64.7%	62.9%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	74.0%	71.2%	69.1%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	17.2%	24.6%	⇧
	Comprehensive Diabetes Care—LDL-C Screening	66.4%	67.4%	64.8%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	64.2%	58.1%	62.4%	⇔
	Prenatal and Postpartum Care—Postpartum Care	54.2%	48.8%	49.7%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	74.8%	70.4%	76.8%	⇧
	Use of Appropriate Medications for People With Asthma	85.8%	86.6%	92.1%	⇧

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Anthem Blue Cross—Alameda (cont.)	*Well-Child Visits in the First 15 Months of Life (Six or More Visits)*	NR	22.0%	33.3%	⇧
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.1%	65.5%	58.2%	⇩
Anthem Blue Cross—Contra Costa	*Adolescent Well-Care Visits*	24.8%	28.2%	29.2%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	87.6%	88.8%	88.7%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	NA	NA	36.6%	Not comparable
	Breast Cancer Screening	42.8%	35.9%	38.6%	⇔
	Cervical Cancer Screening	57.2%	54.5%	55.5%	⇔
	Childhood Immunization Status—Combination 3	- -	48.8%	62.8%	⇧
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	45.8%	48.8%	43.3%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	25.0%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	60.0%	71.1%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	73.6%	72.5%	71.1%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	21.3%	30.0%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	61.1%	56.3%	65.6%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.1%	63.8%	65.6%	⇔
	Prenatal and Postpartum Care—Postpartum Care	44.2%	51.9%	47.1%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	73.2%	72.1%	79.3%	⇔
	Use of Appropriate Medications for People With Asthma	89.2%	90.8%	86.9%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	NR	39.4%	31.8%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	59.3%	58.6%	55.7%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Anthem Blue Cross—Fresno	*Adolescent Well-Care Visits*	41.0%	44.2%	38.2%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	87.3%	86.2%	87.3%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	73.1%	35.2%	34.8%	⇔
	Breast Cancer Screening	46.9%	45.7%	45.1%	⇔
	Cervical Cancer Screening	69.4%	70.6%	73.9%	⇔
	Childhood Immunization Status—Combination 3	- -	65.5%	73.6%	⇧
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	54.9%	57.1%	57.4%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	21.3%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	59.6%	46.0%	⇧
	Comprehensive Diabetes Care—HbA1c Testing	82.8%	81.1%	85.2%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	20.8%	27.9%	⇧
	Comprehensive Diabetes Care—LDL-C Screening	74.8%	73.5%	77.9%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.5%	74.5%	79.8%	⇔
	Prenatal and Postpartum Care—Postpartum Care	57.6%	67.1%	58.5%	⇩
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.4%	87.2%	85.7%	⇔
	Use of Appropriate Medications for People With Asthma	90.1%	92.4%	91.4%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	54.1%	58.5%	61.3%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	80.3%	81.9%	73.8%	⇩

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Anthem Blue Cross—Sacramento	*Adolescent Well-Care Visits*	36.3%	36.6%	34.3%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	90.7%	91.5%	92.2%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	73.7%	27.7%	25.2%	⇔
	Breast Cancer Screening	43.7%	45.5%	43.2%	⇔
	Cervical Cancer Screening	62.2%	67.3%	64.5%	⇔
	Childhood Immunization Status—Combination 3	- -	63.9%	56.3%	⇩
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.0%	47.9%	43.1%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	32.4%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	47.0%	59.4%	⇩
	Comprehensive Diabetes Care—HbA1c Testing	68.0%	71.2%	72.5%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	21.1%	22.6%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	66.1%	66.6%	67.5%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.6%	67.3%	72.4%	⇔
	Prenatal and Postpartum Care—Postpartum Care	59.5%	51.2%	55.3%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	77.0%	81.5%	74.7%	⇩
	Use of Appropriate Medications for People With Asthma	85.1%	85.4%	90.3%	⇧
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	53.0%	52.3%	45.7%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.2%	68.5%	71.9%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Anthem Blue Cross—San Francisco	*Adolescent Well-Care Visits*	40.0%	53.2%	53.6%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	90.4%	94.7%	95.4%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	NA	46.6%	42.5%	⇔
	Breast Cancer Screening	58.9%	57.3%	59.5%	⇔
	Cervical Cancer Screening	70.8%	69.2%	71.9%	⇔
	Childhood Immunization Status—Combination 3	- -	79.5%	75.9%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.9%	56.7%	61.3%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	37.9%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	35.5%	42.7%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	74.3%	80.8%	81.4%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	32.5%	26.6%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	65.8%	78.3%	70.4%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.3%	72.9%	80.4%	⇔
	Prenatal and Postpartum Care—Postpartum Care	51.9%	63.0%	54.4%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	75.5%	89.4%	82.6%	⇔
	Use of Appropriate Medications for People With Asthma	88.2%	89.3%	88.0%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	NR	67.5%	64.0%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.1%	85.2%	78.7%	⇩

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Anthem Blue Cross—San Joaquin	*Adolescent Well-Care Visits*	35.4%	41.2%	41.7%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	82.4%	86.3%	82.1%	⇩
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	NA	18.8%	18.4%	⇔
	Breast Cancer Screening	45.4%	45.6%	45.1%	⇔
	Cervical Cancer Screening	57.3%	60.6%	61.6%	⇔
	Childhood Immunization Status—Combination 3	- -	68.1%	68.3%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.8%	48.5%	50.0%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	26.9%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	53.6%	68.3%	⇩
	Comprehensive Diabetes Care—HbA1c Testing	72.5%	74.9%	71.9%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	29.0%	19.7%	⇩
	Comprehensive Diabetes Care—LDL-C Screening	71.9%	69.5%	73.0%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.9%	68.6%	73.8%	⇔
	Prenatal and Postpartum Care—Postpartum Care	49.3%	47.6%	52.4%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	78.5%	78.7%	77.7%	⇔
	Use of Appropriate Medications for People With Asthma	91.5%	93.9%	92.6%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	50.3%	59.8%	52.2%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.1%	78.7%	75.7%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Anthem Blue Cross—Santa Clara	*Adolescent Well-Care Visits*	44.7%	41.0%	39.7%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	85.6%	89.8%	90.5%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	80.4%	21.7%	24.1%	⇔
	Breast Cancer Screening	62.6%	64.7%	64.5%	⇔
	Cervical Cancer Screening	71.8%	70.1%	72.4%	⇔
	Childhood Immunization Status—Combination 3	- -	63.6%	48.1%	⇩
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	63.6%	57.3%	67.4%	⇧
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	32.5%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	50.7%	62.0%	⇩
	Comprehensive Diabetes Care—HbA1c Testing	82.4%	80.3%	81.6%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	27.3%	37.0%	⇧
	Comprehensive Diabetes Care—LDL-C Screening	80.0%	77.5%	80.4%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	NR	71.3%	80.7%	⇧
	Prenatal and Postpartum Care—Postpartum Care	50.1%	50.2%	56.0%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	72.6%	80.1%	73.4%	⇩
	Use of Appropriate Medications for People With Asthma	89.2%	85.8%	86.1%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	NR	30.0%	40.6%	⇧
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.7%	71.5%	69.1%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Anthem Blue Cross—Stanislaus	*Adolescent Well-Care Visits*	23.8%	32.2%	22.1%	⇩
	Appropriate Treatment for Children With Upper Respiratory Infection	82.8%	89.8%	91.6%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	72.0%	20.0%	22.5%	⇔
	Breast Cancer Screening	44.6%	45.2%	48.1%	⇔
	Cervical Cancer Screening	58.9%	61.6%	64.8%	⇔
	Childhood Immunization Status—Combination 3	- -	62.7%	67.4%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	39.4%	50.2%	48.7%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	41.5%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	35.2%	47.0%	⇩
	Comprehensive Diabetes Care—HbA1c Testing	73.8%	82.3%	77.9%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	33.5%	35.1%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	68.8%	75.7%	77.2%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	71.2%	70.6%	73.6%	⇔
	Prenatal and Postpartum Care—Postpartum Care	57.9%	56.3%	53.8%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.7%	85.0%	83.1%	⇔
	Use of Appropriate Medications for People With Asthma	85.8%	90.0%	90.7%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	46.1%	40.0%	38.1%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	63.9%	65.0%	62.3%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Anthem Blue Cross—Tulare	*Adolescent Well-Care Visits*	31.9%	40.0%	38.7%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	75.1%	84.6%	83.9%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	80.5%	21.1%	24.4%	⇔
	Breast Cancer Screening	53.0%	53.4%	50.5%	⇔
	Cervical Cancer Screening	75.6%	75.0%	74.7%	⇔
	Childhood Immunization Status—Combination 3	- -	73.6%	72.5%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.0%	60.0%	46.1%	⇩
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	30.4%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	42.5%	51.1%	⇩
	Comprehensive Diabetes Care—HbA1c Testing	76.6%	82.2%	73.9%	⇩
	Comprehensive Diabetes Care—LDL-C Control	- -	28.8%	25.4%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	74.1%	77.8%	65.3%	⇩
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.8%	79.7%	72.6%	⇩
	Prenatal and Postpartum Care—Postpartum Care	63.0%	68.3%	63.6%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	81.4%	89.8%	82.7%	⇩
	Use of Appropriate Medications for People With Asthma	89.5%	91.5%	92.4%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	50.0%	52.9%	52.8%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.9%	77.3%	70.8%	⇩

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
CalOptima—Orange	*Adolescent Well-Care Visits*	57.6%	56.3%	56.3%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	79.7%	83.2%	84.9%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	75.4%	20.9%	24.1%	⇧
	Breast Cancer Screening	55.1%	55.2%	56.2%	⇔
	Cervical Cancer Screening	72.7%	70.1%	74.3%	⇔
	Childhood Immunization Status—Combination 3	- -	76.9%	79.1%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	68.3%	70.4%	66.0%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	35.5%	34.0%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	38.1%	40.3%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	83.8%	84.5%	83.2%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	36.2%	36.1%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	81.6%	82.8%	81.2%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.9%	80.7%	82.2%	⇔
	Prenatal and Postpartum Care—Postpartum Care	59.8%	64.9%	58.3%	⇩
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.8%	86.0%	76.7%	⇩
	Use of Appropriate Medications for People With Asthma	88.5%	90.8%	90.2%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	68.1%	74.3%	65.4%	⇩
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.2%	83.9%	84.9%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Care 1st—San Diego	*Adolescent Well-Care Visits*	NA	40.6%	40.9%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	NA	86.8%	91.3%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	NA	NA	NA	Not comparable
	Breast Cancer Screening	NA	NA	34.4%	Not comparable
	Cervical Cancer Screening	NA	58.9%	60.6%	⇔
	Childhood Immunization Status—Combination 3	- -	61.5%	76.4%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	NA	NA	48.4%	Not comparable
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	NA	29.0%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	NA	38.7%	Not comparable
	Comprehensive Diabetes Care—HbA1c Testing	NA	NA	85.5%	Not comparable
	Comprehensive Diabetes Care—LDL-C Control	- -	NA	40.3%	Not comparable
	Comprehensive Diabetes Care—LDL-C Screening	NA	NA	72.6%	Not comparable
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	NA	NA	87.1%	Not comparable
	Prenatal and Postpartum Care—Postpartum Care	NA	63.2%	62.7%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	NA	88.2%	81.7%	⇔
	Use of Appropriate Medications for People With Asthma	NA	NA	NA	Not comparable
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	NA	53.3%	73.1%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NA	72.3%	68.4%	⇔

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**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
CenCal Health—San Luis Obispo	*Adolescent Well-Care Visits*	- -	- -	40.0%	Not comparable
	Appropriate Treatment for Children With Upper Respiratory Infection	- -	- -	89.2%	Not comparable
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	- -	- -	NA	Not comparable
	Breast Cancer Screening	- -	- -	NA	Not comparable
	Cervical Cancer Screening	- -	- -	63.2%	Not comparable
	Childhood Immunization Status—Combination 3	- -	- -	NA	Not comparable
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	- -	- -	NA	Not comparable
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	- -	NA	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	- -	NA	Not comparable
	Comprehensive Diabetes Care—HbA1c Testing	- -	- -	NA	Not comparable
	Comprehensive Diabetes Care—LDL-C Control	- -	- -	NA	Not comparable
	Comprehensive Diabetes Care—LDL-C Screening	- -	- -	NA	Not comparable
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	- -	- -	NA	Not comparable
	Prenatal and Postpartum Care—Postpartum Care	- -	- -	73.1%	Not comparable
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	- -	- -	93.7%	Not comparable
	Use of Appropriate Medications for People With Asthma	- -	- -	NA	Not comparable
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	- -	- -	NA	Not comparable
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	- -	- -	68.8%	Not comparable

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
CenCal Health—Santa Barbara	*Adolescent Well-Care Visits*	33.1%	35.9%	42.4%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	71.5%	78.2%	84.4%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	49.8%	46.7%	45.4%	⇔
	Breast Cancer Screening	56.1%	56.7%	57.4%	⇔
	Cervical Cancer Screening	70.6%	67.4%	67.4%	⇔
	Childhood Immunization Status—Combination 3	- -	84.6%	81.7%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	81.6%	79.0%	79.9%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	52.4%	42.0%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	23.5%	29.5%	⇩
	Comprehensive Diabetes Care—HbA1c Testing	93.2%	88.6%	84.2%	⇩
	Comprehensive Diabetes Care—LDL-C Control	- -	46.4%	48.8%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	85.0%	81.8%	81.0%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.2%	80.4%	77.5%	⇔
	Prenatal and Postpartum Care—Postpartum Care	73.5%	77.9%	76.6%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.5%	85.1%	80.4%	⇩
	Use of Appropriate Medications for People With Asthma	90.0%	90.3%	91.5%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	63.1%	63.9%	59.7%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.0%	71.7%	72.2%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Central CA Alliance for Health—Monterey/Santa Cruz	*Adolescent Well-Care Visits*	43.6%	47.2%	39.9%	⇩
	Appropriate Treatment for Children With Upper Respiratory Infection	91.8%	94.5%	94.5%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	71.6%	34.1%	30.3%	⇔
	Breast Cancer Screening	58.6%	59.1%	62.0%	⇧
	Cervical Cancer Screening	77.4%	80.5%	68.8%	⇩
	Childhood Immunization Status—Combination 3	- -	75.7%	67.9%	⇩
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	68.6%	71.3%	51.8%	⇩
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	46.2%	39.9%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	31.6%	36.3%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	84.2%	85.6%	80.3%	⇩
	Comprehensive Diabetes Care—LDL-C Control	- -	38.2%	36.1%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	74.9%	80.3%	77.2%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.1%	81.0%	76.6%	⇔
	Prenatal and Postpartum Care—Postpartum Care	72.0%	71.3%	71.8%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.4%	84.2%	77.9%	⇧
	Use of Appropriate Medications for People With Asthma	87.9%	88.7%	90.8%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	75.2%	77.9%	49.9%	⇩
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.1%	78.1%	77.3%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Community Health Group—San Diego	*Adolescent Well-Care Visits*	36.5%	36.0%	39.9%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	82.7%	84.0%	84.8%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	81.1%	24.2%	20.5%	⇔
	Breast Cancer Screening	48.8%	49.9%	52.1%	⇔
	Cervical Cancer Screening	66.7%	66.4%	65.9%	⇔
	Childhood Immunization Status—Combination 3	- -	64.2%	77.4%	⇧
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	55.5%	46.0%	46.6%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	27.7%	29.5%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	49.1%	48.5%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	72.0%	77.6%	79.8%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	34.3%	37.4%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	75.4%	74.0%	77.7%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.2%	76.2%	73.4%	⇔
	Prenatal and Postpartum Care—Postpartum Care	49.6%	51.3%	54.3%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	75.9%	73.0%	76.4%	⇔
	Use of Appropriate Medications for People With Asthma	85.6%	86.8%	84.7%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	44.5%	46.5%	51.0%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.7%	74.7%	75.9%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Contra Costa Health Plan—Contra Costa	*Adolescent Well-Care Visits*	37.0%	38.9%	47.4%	⇧
	Appropriate Treatment for Children With Upper Respiratory Infection	91.8%	91.9%	93.6%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	61.7%	37.5%	32.5%	⇔
	Breast Cancer Screening	47.5%	47.6%	43.7%	⇩
	Cervical Cancer Screening	67.4%	69.7%	67.9%	⇔
	Childhood Immunization Status—Combination 3	- -	80.0%	82.5%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	54.0%	52.6%	53.5%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	32.8%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	38.0%	42.2%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	80.3%	82.0%	83.0%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	42.1%	42.2%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	70.1%	77.9%	79.4%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.4%	81.3%	82.3%	⇔
	Prenatal and Postpartum Care—Postpartum Care	56.3%	61.5%	68.1%	⇧
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.3%	80.2%	83.5%	⇔
	Use of Appropriate Medications for People With Asthma	88.1%	86.2%	85.9%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	62.6%	68.3%	71.0%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.7%	66.5%	77.4%	⇧

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Health Net—Fresno	*Adolescent Well-Care Visits*	33.8%	48.0%	49.3%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	86.8%	87.1%	87.1%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	63.6%	31.9%	45.7%	⇧
	Breast Cancer Screening	45.5%	45.5%	47.8%	⇔
	Cervical Cancer Screening	68.2%	70.8%	69.9%	⇔
	Childhood Immunization Status—Combination 3	- -	66.2%	77.4%	⇧
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.6%	60.9%	64.8%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	36.4%	36.2%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	39.3%	39.9%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	83.3%	84.2%	85.2%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	33.0%	34.2%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	76.2%	78.9%	79.2%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.6%	73.8%	77.3%	⇔
	Prenatal and Postpartum Care—Postpartum Care	62.7%	60.4%	62.3%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.7%	88.7%	90.2%	⇔
	Use of Appropriate Medications for People With Asthma	93.0%	94.2%	95.1%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	60.9%	63.1%	67.0%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.9%	83.4%	85.3%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Health Net—Kern	*Adolescent Well-Care Visits*	26.8%	31.9%	39.3%	⇧
	Appropriate Treatment for Children With Upper Respiratory Infection	69.0%	74.2%	77.7%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	79.1%	22.8%	21.4%	⇔
	Breast Cancer Screening	34.6%	39.5%	44.5%	⇔
	Cervical Cancer Screening	54.4%	63.6%	64.3%	⇔
	Childhood Immunization Status—Combination 3	- -	65.7%	65.6%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	51.8%	58.6%	54.8%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	37.4%	32.7%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	43.9%	43.9%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	77.7%	79.6%	80.3%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	34.0%	37.1%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	72.6%	73.4%	76.6%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	75.6%	76.2%	82.3%	⇧
	Prenatal and Postpartum Care—Postpartum Care	59.3%	61.3%	59.7%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.0%	83.0%	87.4%	⇔
	Use of Appropriate Medications for People With Asthma	87.6%	90.2%	87.3%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	41.8%	47.0%	48.9%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.9%	76.4%	66.8%	⇩

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Health Net—Los Angeles	*Adolescent Well-Care Visits*	35.6%	35.7%	38.4%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	72.6%	78.7%	80.3%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	74.5%	29.9%	29.2%	⇔
	Breast Cancer Screening	39.2%	43.6%	49.2%	⇧
	Cervical Cancer Screening	65.9%	71.7%	73.2%	⇔
	Childhood Immunization Status—Combination 3	- -	71.5%	77.2%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.6%	59.7%	64.4%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	28.1%	28.8%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	45.0%	40.9%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	78.9%	82.4%	84.7%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	32.1%	36.5%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	75.4%	78.5%	80.2%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.9%	81.7%	82.5%	⇔
	Prenatal and Postpartum Care—Postpartum Care	56.9%	53.7%	56.2%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	81.1%	80.6%	83.0%	⇔
	Use of Appropriate Medications for People With Asthma	82.7%	85.8%	86.3%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	39.0%	41.6%	50.0%	⇧
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.9%	72.8%	78.6%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Health Net—Sacramento	*Adolescent Well-Care Visits*	39.0%	46.6%	46.7%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	73.6%	79.0%	80.0%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	70.8%	27.6%	21.7%	⇔
	Breast Cancer Screening	44.4%	38.9%	44.6%	⇧
	Cervical Cancer Screening	57.7%	67.7%	65.1%	⇔
	Childhood Immunization Status—Combination 3	- -	70.1%	66.0%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.6%	56.6%	57.9%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	28.4%	35.4%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	46.2%	38.4%	⇧
	Comprehensive Diabetes Care—HbA1c Testing	78.7%	80.8%	81.3%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	26.8%	33.5%	⇧
	Comprehensive Diabetes Care—LDL-C Screening	76.8%	72.0%	75.8%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.6%	78.0%	79.9%	⇔
	Prenatal and Postpartum Care—Postpartum Care	58.1%	55.8%	57.0%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.4%	83.1%	84.9%	⇔
	Use of Appropriate Medications for People With Asthma	85.1%	85.4%	84.3%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	64.1%	64.0%	60.6%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.8%	74.5%	73.6%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Health Net—San Diego	*Adolescent Well-Care Visits*	29.2%	41.7%	37.1%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	84.6%	90.9%	93.0%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	75.8%	28.6%	31.7%	⇔
	Breast Cancer Screening	41.0%	46.6%	45.3%	⇔
	Cervical Cancer Screening	62.6%	69.1%	60.6%	⇩
	Childhood Immunization Status—Combination 3	- -	73.9%	75.5%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	55.8%	54.3%	60.2%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	38.2%	35.3%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	36.0%	36.0%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	88.3%	87.6%	89.6%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	41.9%	52.6%	⇧
	Comprehensive Diabetes Care—LDL-C Screening	81.8%	80.1%	83.7%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.8%	82.3%	85.1%	⇔
	Prenatal and Postpartum Care—Postpartum Care	54.5%	58.8%	58.5%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.6%	88.0%	88.5%	⇔
	Use of Appropriate Medications for People With Asthma	90.5%	85.6%	89.0%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	44.8%	53.8%	49.3%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.2%	72.0%	67.6%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Health Net—Stanislaus	*Adolescent Well-Care Visits*	26.9%	36.0%	36.6%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	87.2%	90.3%	89.4%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	NA	19.8%	20.5%	⇔
	Breast Cancer Screening	NA	52.7%	48.4%	⇔
	Cervical Cancer Screening	60.1%	61.0%	65.1%	⇔
	Childhood Immunization Status—Combination 3	- -	67.8%	74.6%	⇧
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.2%	55.1%	60.8%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	36.4%	45.0%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	44.9%	31.3%	⇧
	Comprehensive Diabetes Care—HbA1c Testing	86.1%	77.7%	85.4%	⇧
	Comprehensive Diabetes Care—LDL-C Control	- -	32.4%	34.0%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	80.9%	74.5%	78.0%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.6%	72.9%	81.3%	⇧
	Prenatal and Postpartum Care—Postpartum Care	53.6%	65.3%	66.3%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.5%	91.1%	90.9%	⇔
	Use of Appropriate Medications for People With Asthma	NA	90.7%	90.3%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	49.1%	53.5%	52.9%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.0%	76.3%	73.2%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Health Net—Tulare	*Adolescent Well-Care Visits*	29.9%	35.3%	36.5%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	84.1%	83.4%	84.0%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	75.2%	28.4%	25.6%	⇔
	Breast Cancer Screening	41.3%	44.7%	41.5%	⇔
	Cervical Cancer Screening	70.9%	71.4%	71.1%	⇔
	Childhood Immunization Status—Combination 3	- -	77.8%	76.1%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	59.1%	60.4%	69.8%	⇧
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	29.7%	38.4%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	39.2%	37.9%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	82.1%	85.1%	86.4%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	27.5%	31.5%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	74.5%	76.6%	79.6%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.4%	82.9%	85.1%	⇔
	Prenatal and Postpartum Care—Postpartum Care	62.7%	64.0%	65.0%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.9%	92.7%	91.1%	⇔
	Use of Appropriate Medications for People With Asthma	95.3%	95.4%	88.6%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	49.1%	49.4%	60.9%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.0%	75.0%	79.3%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Health Plan of San Joaquin—San Joaquin	*Adolescent Well-Care Visits*	40.1%	44.8%	53.8%	⇧
	Appropriate Treatment for Children With Upper Respiratory Infection	78.4%	77.0%	82.5%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	74.8%	26.3%	23.3%	⇔
	Breast Cancer Screening	52.9%	55.8%	55.4%	⇔
	Cervical Cancer Screening	62.6%	68.1%	67.6%	⇔
	Childhood Immunization Status—Combination 3	- -	72.0%	74.7%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	42.3%	47.4%	58.9%	⇧
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	28.5%	34.1%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	47.2%	42.7%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	75.4%	80.8%	79.0%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	32.8%	30.7%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	74.0%	78.1%	77.2%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.3%	72.3%	77.4%	⇔
	Prenatal and Postpartum Care—Postpartum Care	57.2%	63.7%	60.8%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	78.3%	83.5%	83.2%	⇔
	Use of Appropriate Medications for People With Asthma	84.6%	86.7%	86.8%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	55.5%	67.6%	76.2%	⇧
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	79.3%	82.0%	83.9%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Health Plan of San Mateo—San Mateo	*Adolescent Well-Care Visits*	33.8%	34.8%	41.6%	⇧
	Appropriate Treatment for Children With Upper Respiratory Infection	90.2%	91.4%	89.0%	⇩
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	60.6%	28.2%	26.4%	⇔
	Breast Cancer Screening	54.1%	56.2%	55.9%	⇔
	Cervical Cancer Screening	55.0%	60.4%	58.7%	⇔
	Childhood Immunization Status—Combination 3	- -	76.6%	79.1%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	54.7%	53.1%	59.7%	⇧
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	28.9%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	49.1%	43.1%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	84.2%	80.9%	83.9%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	31.3%	42.7%	⇧
	Comprehensive Diabetes Care—LDL-C Screening	79.8%	74.8%	79.4%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.6%	80.0%	85.2%	⇧
	Prenatal and Postpartum Care—Postpartum Care	55.0%	54.3%	60.1%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	70.6%	78.0%	77.5%	⇔
	Use of Appropriate Medications for People With Asthma	89.0%	89.7%	90.1%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	54.0%	58.4%	61.1%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.2%	71.4%	72.8%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Inland Empire Health Plan—Riverside/San Bernardino	*Adolescent Well-Care Visits*	38.1%	38.4%	40.0%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	73.0%	80.8%	85.7%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	79.2%	27.1%	29.9%	⇔
	Breast Cancer Screening	49.0%	50.0%	49.0%	⇔
	Cervical Cancer Screening	65.5%	66.9%	61.9%	⇔
	Childhood Immunization Status—Combination 3	- -	69.0%	69.7%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	60.9%	54.9%	50.2%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	32.3%	30.2%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	43.2%	46.9%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	80.0%	80.1%	80.2%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	35.7%	36.9%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	80.0%	80.8%	79.5%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	91.3%	88.3%	78.7%	⇩
	Prenatal and Postpartum Care—Postpartum Care	60.0%	61.2%	57.1%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.2%	82.9%	84.5%	⇔
	Use of Appropriate Medications for People With Asthma	88.3%	89.8%	88.3%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	61.3%	58.1%	48.6%	⇩
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.7%	73.8%	73.1%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Kaiser Permanente (North)—Sacramento	*Adolescent Well-Care Visits*	25.5%	26.0%	32.1%	⇧
	Appropriate Treatment for Children With Upper Respiratory Infection	96.4%	96.7%	98.0%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	75.5%	35.4%	44.3%	⇔
	Breast Cancer Screening	62.1%	62.7%	69.3%	⇧
	Cervical Cancer Screening	76.8%	77.4%	78.1%	⇔
	Childhood Immunization Status—Combination 3	- -	73.0%	73.0%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	65.7%	66.0%	67.7%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	42.5%	43.3%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	26.5%	23.8%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	85.0%	89.9%	90.1%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	53.1%	56.8%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	79.2%	85.5%	85.6%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	91.7%	87.6%	83.8%	⇩
	Prenatal and Postpartum Care—Postpartum Care	64.3%	71.3%	70.3%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.0%	87.5%	89.1%	⇔
	Use of Appropriate Medications for People With Asthma	92.0%	96.2%	96.7%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	65.8%	66.7%	73.9%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	56.5%	62.1%	64.6%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Kaiser Permanente (South)—San Diego	*Adolescent Well-Care Visits*	19.5%	28.0%	28.3%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	92.0%	95.1%	96.7%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	27.2%	20.3%	25.6%	⇔
	Breast Cancer Screening	69.3%	70.7%	71.6%	⇔
	Cervical Cancer Screening	74.7%	79.4%	84.3%	⇧
	Childhood Immunization Status—Combination 3	- -	78.2%	73.9%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	67.2%	64.3%	63.3%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	39.7%	38.0%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	25.6%	25.9%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	89.8%	90.6%	90.2%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	48.9%	54.4%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	88.7%	90.1%	88.7%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	91.3%	92.3%	89.6%	⇔
	Prenatal and Postpartum Care—Postpartum Care	45.4%	43.6%	50.5%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	75.9%	83.0%	86.6%	⇔
	Use of Appropriate Medications for People With Asthma	82.9%	91.9%	89.4%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	35.5%	42.2%	57.9%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	53.4%	59.4%	70.8%	⇧

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Kern Family Health Care—Kern	*Adolescent Well-Care Visits*	35.8%	37.2%	38.0%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	76.7%	85.0%	86.0%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	76.9%	23.3%	20.6%	⇔
	Breast Cancer Screening	49.7%	49.9%	48.0%	⇔
	Cervical Cancer Screening	63.1%	64.1%	62.6%	⇩
	Childhood Immunization Status—Combination 3	- -	73.5%	77.1%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	37.7%	42.1%	NR	Not comparable
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	34.4%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	48.1%	38.4%	⇧
	Comprehensive Diabetes Care—HbA1c Testing	75.2%	74.8%	79.8%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	34.7%	37.2%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	69.6%	67.6%	76.4%	⇧
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.0%	73.8%	79.6%	⇔
	Prenatal and Postpartum Care—Postpartum Care	63.8%	58.6%	60.6%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.3%	78.4%	75.9%	⇔
	Use of Appropriate Medications for People With Asthma	85.6%	85.9%	81.5%	⇩
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	52.1%	60.1%	54.3%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.6%	70.0%	71.3%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
LA Care Health Plan—Los Angeles	*Adolescent Well-Care Visits*	31.6%	37.0%	45.7%	⇧
	Appropriate Treatment for Children With Upper Respiratory Infection	78.3%	80.0%	81.2%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	64.6%	32.5%	30.9%	⇔
	Breast Cancer Screening	45.5%	49.4%	52.2%	⇧
	Cervical Cancer Screening	70.4%	67.3%	72.0%	⇔
	Childhood Immunization Status—Combination 3	- -	74.3%	78.0%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	39.4%	50.8%	57.2%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	28.9%	23.4%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	42.7%	47.0%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	74.9%	83.9%	79.3%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	32.3%	34.7%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	73.7%	79.3%	76.2%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	87.9%	74.2%	74.0%	⇔
	Prenatal and Postpartum Care—Postpartum Care	50.2%	55.9%	59.9%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	72.0%	81.4%	84.3%	⇔
	Use of Appropriate Medications for People With Asthma	85.0%	88.7%	88.0%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	46.6%	54.1%	52.2%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.6%	78.5%	80.1%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Molina Healthcare—Riverside/San Bernardino	*Adolescent Well-Care Visits*	44.2%	48.8%	53.9%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	70.9%	78.2%	89.5%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	67.2%	25.8%	18.4%	⇩
	Breast Cancer Screening	41.4%	42.7%	44.2%	⇔
	Cervical Cancer Screening	58.9%	67.0%	70.3%	⇔
	Childhood Immunization Status—Combination 3	- -	65.0%	67.1%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	58.9%	58.6%	55.9%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	27.9%	21.4%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	52.5%	56.5%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	75.2%	76.4%	69.8%	⇩
	Comprehensive Diabetes Care—LDL-C Control	- -	33.8%	27.4%	⇩
	Comprehensive Diabetes Care—LDL-C Screening	68.9%	78.0%	70.6%	⇩
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.4%	79.2%	76.7%	⇔
	Prenatal and Postpartum Care—Postpartum Care	56.3%	53.1%	48.5%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.6%	84.4%	79.1%	⇩
	Use of Appropriate Medications for People With Asthma	81.2%	81.7%	83.8%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	48.1%	49.1%	40.4%	⇩
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.3%	77.9%	77.8%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Molina Healthcare—Sacramento	*Adolescent Well-Care Visits*	50.2%	53.2%	51.6%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	88.2%	90.0%	95.8%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	62.9%	27.3%	30.3%	⇔
	Breast Cancer Screening	43.8%	46.8%	40.9%	⇔
	Cervical Cancer Screening	59.3%	66.6%	65.6%	⇔
	Childhood Immunization Status—Combination 3	- -	65.5%	63.7%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	64.9%	63.5%	61.3%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	27.8%	32.8%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	50.2%	44.9%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	79.9%	73.3%	78.6%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	34.1%	37.7%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	71.0%	67.8%	68.6%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.2%	76.5%	79.6%	⇔
	Prenatal and Postpartum Care—Postpartum Care	48.8%	53.8%	51.9%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	75.1%	79.8%	78.0%	⇔
	Use of Appropriate Medications for People With Asthma	83.3%	75.0%	86.7%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	59.7%	57.5%	60.4%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.6%	76.6%	75.9%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Molina Healthcare—San Diego	*Adolescent Well-Care Visits*	49.1%	46.6%	56.3%	⇧
	Appropriate Treatment for Children With Upper Respiratory Infection	87.9%	90.5%	96.1%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	61.2%	29.3%	20.6%	⇩
	Breast Cancer Screening	NA	49.1%	47.4%	⇔
	Cervical Cancer Screening	66.0%	68.5%	70.6%	⇔
	Childhood Immunization Status—Combination 3	- -	66.9%	77.8%	⇧
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.8%	62.3%	58.1%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	32.8%	32.0%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	47.4%	48.5%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	81.0%	84.0%	79.3%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	37.5%	33.8%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	74.0%	78.8%	76.9%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.6%	82.1%	79.0%	⇔
	Prenatal and Postpartum Care—Postpartum Care	56.8%	55.2%	62.5%	⇧
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.6%	88.4%	87.4%	⇔
	Use of Appropriate Medications for People With Asthma	NA	79.1%	83.0%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	81.6%	83.4%	76.4%	⇩
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.8%	78.8%	82.4%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Partnership Health Plan — Napa/Solano/Yolo	*Adolescent Well-Care Visits*	35.4%	37.7%	39.4%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	88.4%	91.0%	91.8%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	77.0%	20.7%	22.4%	⇔
	Breast Cancer Screening	55.5%	57.9%	56.1%	⇔
	Cervical Cancer Screening	63.7%	63.1%	66.0%	⇔
	Childhood Immunization Status—Combination 3	- -	75.4%	72.3%	⇔
	Comprehensive Diabetes Care— Eye Exam (Retinal) Performed	67.0%	68.8%	60.9%	⇩
	*Comprehensive Diabetes Care— HbA1c Control (< 7.0%)***	- -	40.6%	37.3%	Not comparable
	Comprehensive Diabetes Care— HbA1c Poor Control (> 9.0%)	- -	34.5%	36.9%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	83.4%	86.3%	79.0%	⇩
	Comprehensive Diabetes Care—LDL-C Control	- -	47.5%	42.9%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	79.1%	81.6%	78.9%	⇔
	Comprehensive Diabetes Care— Medical Attention for Nephropathy	81.3%	86.8%	80.7%	⇩
	Prenatal and Postpartum Care—Postpartum Care	64.3%	64.7%	68.4%	⇔
	Prenatal and Postpartum Care— Timeliness of Prenatal Care	84.6%	86.8%	88.6%	⇔
	Use of Appropriate Medications for People With Asthma	88.9%	89.5%	89.7%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	67.9%	69.5%	61.7%	⇩
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.5%	70.0%	68.0%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
San Francisco Health Plan—San Francisco	*Adolescent Well-Care Visits*	46.5%	52.8%	52.4%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	92.6%	94.4%	95.3%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	71.6%	31.4%	32.2%	⇔
	Breast Cancer Screening	57.7%	58.3%	55.7%	⇔
	Cervical Cancer Screening	77.2%	74.2%	80.6%	⇧
	Childhood Immunization Status—Combination 3	- -	90.7%	90.3%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	64.8%	66.5%	73.1%	⇧
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	39.3%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	27.7%	25.9%	⇔
	Comprehensive Diabetes Care—HbA1c Testing	86.0%	86.4%	89.5%	⇔
	Comprehensive Diabetes Care—LDL-C Control	- -	46.0%	47.4%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	77.9%	79.4%	80.8%	⇔
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.9%	82.2%	87.1%	⇧
	Prenatal and Postpartum Care—Postpartum Care	55.9%	64.2%	69.5%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.3%	87.7%	92.3%	⇧
	Use of Appropriate Medications for People With Asthma	92.1%	90.1%	90.6%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	82.6%	75.4%	80.1%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.5%	81.3%	82.4%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Santa Clara Family Health—Santa Clara	*Adolescent Well-Care Visits*	35.0%	39.4%	42.2%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	89.8%	91.3%	92.6%	⇧
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	80.5%	27.4%	25.1%	⇔
	Breast Cancer Screening	56.1%	57.8%	55.2%	⇩
	Cervical Cancer Screening	70.4%	73.5%	74.4%	⇔
	Childhood Immunization Status—Combination 3	- -	78.5%	75.0%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	51.7%	56.3%	59.0%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	33.6%	NR	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	45.3%	38.7%	⇧
	Comprehensive Diabetes Care—HbA1c Testing	84.5%	80.3%	85.7%	⇧
	Comprehensive Diabetes Care—LDL-C Control	- -	29.8%	42.1%	⇧
	Comprehensive Diabetes Care—LDL-C Screening	76.7%	70.0%	78.2%	⇧
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.9%	71.4%	77.7%	⇧
	Prenatal and Postpartum Care—Postpartum Care	58.3%	61.9%	66.4%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.9%	84.3%	83.2%	⇔
	Use of Appropriate Medications for People With Asthma	95.7%	87.9%	96.5%	⇧
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	59.4%	59.0%	60.0%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.8%	73.1%	73.1%	⇔

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Table B.1––Medi-Cal Managed Care HEDIS 2009 Trend Table

Health Plan and County	Measure	Three-Year Trend			2008–2009 Rate Difference
		2007	2008	2009	
Western Health Advantage—Sacramento	*Adolescent Well-Care Visits*	30.9%	32.4%	37.7%	⇔
	Appropriate Treatment for Children With Upper Respiratory Infection	92.8%	95.5%	95.3%	⇔
	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	72.3%	31.1%	51.2%	⇔
	Breast Cancer Screening	46.6%	41.4%	43.1%	⇔
	Cervical Cancer Screening	58.4%	59.9%	65.0%	⇔
	Childhood Immunization Status—Combination 3	- -	57.9%	59.8%	⇔
	Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.3%	60.8%	63.9%	⇔
	*Comprehensive Diabetes Care—HbA1c Control (< 7.0%)***	- -	24.1%	35.1%	Not comparable
	Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0%)	- -	51.6%	34.9%	⇧
	Comprehensive Diabetes Care—HbA1c Testing	82.0%	78.8%	88.7%	⇧
	Comprehensive Diabetes Care—LDL-C Control	- -	37.0%	42.6%	⇔
	Comprehensive Diabetes Care—LDL-C Screening	69.6%	67.2%	77.7%	⇧
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	70.6%	73.7%	84.3%	⇧
	Prenatal and Postpartum Care—Postpartum Care	NR	53.3%	55.4%	⇔
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	NR	71.0%	72.5%	⇔
	Use of Appropriate Medications for People With Asthma	83.8%	84.0%	84.0%	⇔
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	NR	48.8%	60.8%	⇔
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NR	61.1%	68.1%	⇧

*NCQA inverted the rate for this measure in 2008. The 2007 rate is not reported as an inverted rate.

**A comparison of the rate for this measure was not performed due to significant changes in methodology from the prior year.

Health Plan Name and County	Total Measures Below MPL (●)	Total Measures At or Above HPL (O)
Alameda Alliance for Health—Alameda	3	1
Anthem Blue Cross—Alameda	10	1
Anthem Blue Cross—Contra Costa	10	1
Anthem Blue Cross—Fresno	0	0
Anthem Blue Cross—Sacramento	7	0
Anthem Blue Cross—San Francisco	0	2
Anthem Blue Cross—San Joaquin	5	1
Anthem Blue Cross—Santa Clara	4	1
Anthem Blue Cross—Stanislaus	3	0
Anthem Blue Cross—Tulare	2	1
CalOptima—Orange	0	2
Care 1st—San Diego	1	1
CenCal Health—San Luis Obispo	0	2
CenCal Health—Santa Barbara	0	6
Central CA Alliance for Health—Monterey/Santa Cruz	0	3
Community Health Group—San Diego	3	0
Contra Costa Health Plan—Contra Costa	2	1
Health Net—Fresno	0	3
Health Net—Kern	1	0
Health Net—Los Angeles	0	0
Health Net—Sacramento	1	0
Health Net—San Diego	0	3
Health Net—Stanislaus	1	1
Health Net—Tulare	1	2
Health Plan of San Joaquin—San Joaquin	0	2
Health Plan of San Mateo—San Mateo	0	2
Inland Empire Health Plan—Riverside/San Bernardino	0	0
Kaiser Permanente (North)—Sacramento	1	11
Kaiser Permanente (South)—San Diego	2	8
Kern Family Health Care—Kern	2	0
LA Care Health Plan—Los Angeles	0	1
Molina Healthcare—Riverside/San Bernardino	7	0
Molina Healthcare—Sacramento	2	1
Molina Healthcare—San Diego	2	3
Partnership Health Plan—Napa/Solano/Yolo	0	1
San Francisco Health Plan—San Francisco	0	11
Santa Clara Family Health—Santa Clara	0	1
Western Health Advantage—Sacramento	4	2

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

Health Plan Name and County	AAB	ASM	AWC	BCS	CCS	CDC E	CDC HT	CDC H9	CDC LS	CDC LC	CDC N	CIS 3	PPC Pre	PPC Pst	URI	W15	W34
Alameda Alliance for Health—Alameda						●		●				○	●				
Anthem Blue Cross—Alameda		○	●	●			●	●	●	●	●			●		●	●
Anthem Blue Cross—Contra Costa	○		●	●	●		●	●	●		●			●		●	●
Anthem Blue Cross—Fresno																	
Anthem Blue Cross—Sacramento			●	●			●	●		●		●	●				
Anthem Blue Cross—San Francisco	○														○		
Anthem Blue Cross—San Joaquin	●	○					●	●		●				●			
Anthem Blue Cross—Santa Clara				○				●				●	●			●	
Anthem Blue Cross—Stanislaus			●											●		●	
Anthem Blue Cross—Tulare		○					●		●								
CalOptima—Orange												○					○
Care 1st—San Diego				●							○						
CenCal Health—San Luis Obispo													○	○			
CenCal Health—Santa Barbara	○					○		○		○		○		○			

Health Plan Name and County	AAB	ASM	AWC	BCS	CCS	CDC E	CDC HT	CDC H9	CDC LS	CDC LC	CDC N	CIS 3	PPC Pre	PPC Pst	URI	W15	W34
Central CA Alliance for Health—Monterey/Santa Cruz				○										○	○		
Community Health Group—San Diego	●	●											●				
Contra Costa Health Plan—Contra Costa		●		●								○					
Health Net—Fresno	○	○															○
Health Net—Kern															●		
Health Net—Los Angeles																	
Health Net—Sacramento		●															
Health Net—San Diego							○		○	○							
Health Net—Stanislaus	●							○									
Health Net—Tulare				●		○											○
Health Plan of San Joaquin—San Joaquin																○	○
Health Plan of San Mateo—San Mateo										○		○					
Inland Empire Health Plan—Riverside/San Bernardino																	
Kaiser Permanente (North)—Sacramento	○	○	●	○	○	○	○	○	○	○					○	○	

Health Plan Name and County	AAB	ASM	AWC	BCS	CCS	CDC E	CDC HT	CDC H9	CDC LS	CDC LC	CDC N	CIS 3	PPC Pre	PPC Pst	URI	W15	W34
Kaiser Permanente (South)— San Diego			●	○	○		○	○	○	○	○			●	○		
Kern Family Health Care— Kern		●											●				
LA Care Health Plan— Los Angeles																	○
Molina Healthcare— Riverside/San Bernardino	●	●		●			●	●						●		●	
Molina Healthcare— Sacramento				●										●	○		
Molina Healthcare— San Diego	●	●													○	○	○
Partnership Health Plan— Napa/Solano/Yolo										○							
San Francisco Health Plan— San Francisco					○	○	○	○		○	○	○	○		○	○	○
Santa Clara Family Health— Santa Clara		○															
Western Health Advantage— Sacramento	○	●		●								●	●		○		

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 this. 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* measure. The health plan chooses to perform the administrative method and finds that 4,000 members out of the 10,000 had evidence of a postpartum visit using administrative data. The final rate for this measure, using the administrative method, would be 4,000/10,000, or 40 percent.

Audit Designation

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

Capitation

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

Certified HEDIS Software Vendor

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

CMS

The Centers for Medicare & 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 mentally retarded, 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 is a listing of billing codes generated by the AMA to report the provision of medical services and procedures.

Data Completeness

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

Denominator

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

The DHCS

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

DRG Coding

Diagnostic-Related Group 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 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.

EQRO

An external quality review organization 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: 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 designations, 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

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

HEDIS

The Healthcare Effectiveness Data and Information Set, developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by managed health care organizations.

Formerly the Health Plan Employer Data and Information Set.

HEDIS Measure Determination Standards (HD)

The standards that auditors use during the audit process to assess a health plan's adherence to HEDIS measure specifications.

HEDIS Repository

The data warehouse that stores all data used for HEDIS reporting.

HEDIS Warehouse

See HEDIS repository.

Hib Vaccine

Haemophilus influenzae type b vaccine.

HPL

High performance level: the DHCS defines the HPL as the most recent national HEDIS Medicaid 90th percentile, except for one measure, *Comprehensive Diabetes Care—HbA1c Poor Control*. 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. An external quality review organization (EQRO) that serves as a contractor to state Medicaid plans to provide state-specified activities related to federal requirements for managed care plans. For the Medi-Cal program, the DHCS contracts with HSAG to validate performance measures for its external accountability set, validate quality improvement projects, and produce an annual technical report.

Hybrid Measures

Measures that health plans can report using the hybrid method.

Hybrid Method

The hybrid method requires health plans to identify the eligible population using administrative data and then extract a systematic sample, typically 411 members from the eligible population, which becomes the denominator. The health plans then use administrative data to identify services provided to those sampled members. Finally, the health plan conducts medical record review of members for whom administrative data does not show evidence that a service was provided.

The hybrid method generally produces higher rates but is considerably more labor intensive. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care* 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

Interactive Data Submission System—a tool used to submit data to NCQA.

Inpatient Data

Data derived from an inpatient hospital stay.

IRR

Interrater reliability: The degree of agreement exhibited when a measurement is repeated under the same conditions by different raters.

IS

Information System(s): an automated system for collecting, processing, and transmitting data.

IS Standard

Information System(s) Standards: an NCQA-defined set of standards that measure how an organization collects, stores, analyzes, and reports medical, customer service, member, practitioner, and vendor data.

IPV

Inactivated poliovirus vaccine.

IT

Information technology: 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

Managed care organization.

Medical Record Abstraction

The process used by plans to retrieve and review medical records as part of the hybrid method. Medical record abstraction determines if there is evidence that a specified service was provided, such as a Pap test or an immunization, or gathers information about a specified lab value, such as a blood glucose or cholesterol level.

Medical Record Validation

The process that auditors follow to verify that a health plan's medical record abstraction meets industry standards and that abstracted data are accurate.

Medicaid Percentiles

The NCQA national percentiles for each HEDIS measure for the Medicaid product line, used to compare health plan performance and assess the reliability of a health plan's HEDIS rates.

Membership Data

Information about members in electronic health plan files, such as name, date of birth, gender, current address, and enrollment (i.e., when the member joined the health plan).

Mg/dL

Milligrams per deciliter.

MMR

Measles, mumps, and rubella vaccine.

MPL

The DHCS establishes the minimum performance level (MPL) as the most recent national HEDIS Medicaid 25th percentile, except for one measure, *Comprehensive Diabetes Care—HbA1c Poor Control.* 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: a designation 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 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 two reasons:

1. The health plan chose not to report the measure.
2. The health plan calculated the measure but the result was materially biased.

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 overread a sample of a health plan's medical records as part of the audit process.

PCV

Pneumococcal conjugate vaccine.

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 MCP undergoing the HEDIS audit process, provides information to auditors regarding an MCP'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/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-92 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.