

2014 HEDIS[®] Aggregate Report for Medi-Cal Managed Care

Managed Care Quality and
Monitoring Division
California Department of
Health Care Services

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COMMONLY USED ABBREVIATIONS AND ACRONYMS

Following is a list of abbreviations and acronyms used throughout this report.

- ◆ **AHRQ**—Agency for Healthcare Research and Quality
- ◆ **CMS**—Centers for Medicare & Medicaid Services
- ◆ **COHS**—County-Organized Health System
- ◆ **CP**—commercial plan
- ◆ **DHCS**—California Department of Health Care Services
- ◆ **EAS**—External Accountability Set
- ◆ **EQR**—external quality review
- ◆ **EQRO**—external quality review organization
- ◆ **ESRD**—end-stage renal disease
- ◆ **FFS**—fee-for-service
- ◆ **GMC**—Geographic Managed Care
- ◆ **HEDIS®**—Healthcare Effectiveness Data and Information Set¹
- ◆ **HPL**—high performance level
- ◆ **HSAG**—Health Services Advisory Group, Inc.
- ◆ **IHI**—Institute for Healthcare Improvement
- ◆ **IS**—information systems
- ◆ **LI**—local initiative
- ◆ **MCMC**—Medi-Cal Managed Care
- ◆ **MCP**—Medi-Cal managed care health plan
- ◆ **MHPA**—Medicaid Health Plans of America
- ◆ **MPL**—minimum performance level
- ◆ **NA**—an audit result denoting *Small Denominator*, meaning that although an MCP may have complied with all applicable specifications, the MCP’s denominator is too small to report (less than 30)
- ◆ **NCQA**—National Committee for Quality Assurance
- ◆ **Non-SPD**—Non-Seniors and Persons with Disabilities
- ◆ **PCP**—primary care provider

¹ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- ◆ **QIP**—quality improvement project
- ◆ **SPD**—Seniors and Persons with Disabilities
- ◆ **TPM**—Two-Plan Model
- ◆ **WIC**—Women, Infants, and Children

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

During the 2013 calendar year, DHCS held contracts with 23 full-scope MCPs and three specialty MCPs. The DHCS 2014 EAS for the full-scope MCPs included 14 Healthcare Effectiveness Data and Information Set (HEDIS[®])² measures developed by the National Committee for Quality Assurance (NCQA) and one measure developed by DHCS and the MCPs, with guidance from the external quality review organization (EQRO), to be used for the statewide collaborative quality improvement project (QIP). Several of the HEDIS measures include more than one indicator, bringing the total measure rates required for MCP reporting to 32. In addition to reporting the EAS in 2014, full-scope MCPs were required to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for a selected group of measures.

Due to the small size of specialty MCP populations, DHCS established different performance measure requirements for the specialty MCPs. Instead of requiring a specialty MCP to annually report the full list of performance measure rates as full-scope MCPs do, DHCS requires specialty MCPs to report only two performance measures. In collaboration with DHCS, a specialty MCP may select HEDIS measures or develop measures that are appropriate to the MCP's Medi-Cal population. The measures put forth by the specialty MCP are subject to DHCS approval.

The full-scope MCP performance measure results, which represent calendar year 2013 data, were mixed in that some rates improved from 2013 to 2014, some declined, and some remained relatively stable. MCPs' performance is best for the following measures:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Use of Imaging Studies for Low Back Pain*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity: Total*

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

Although there are many opportunities for improvement, the following measures, which had MCMC weighted averages below the DHCS-established MPLs (national Medicaid 25th percentiles) for at least two consecutive years, show the greatest opportunities for improvement:

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

Consistent with 2013, the SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures were significantly better than the non-SPD rates and the SPD rates for all *Comprehensive Diabetes Care* measures, except *Blood Pressure Control (<140/90 mm Hg)*, were better than the non-SPD rates. The better rates for these measures may be attributed to SPD members having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. For the second consecutive year, the SPD population had a significantly higher rate of readmissions than the non-SPD population, which is also expected based on the greater and often more complicated health needs of these members. Additionally, the rates for several MCP counties for the *Children and Adolescents' Access to Primary Care Practitioners* measures were significantly lower for the SPD population when compared to the non-SPD population. The lower rates for this measure may be attributed to children and adolescents in the SPD population relying on a specialist provider as their care source, based on complicated health care needs, rather than accessing care from a primary care provider (PCP).

The three specialty MCPs had mixed results. Notable results include:

- ◆ AHF Healthcare Center's rate for the *Colorectal Cancer Screening* measure declined significantly from 2013 to 2014, resulting in the rate being below the MPL for the measure, which is based on the national commercial 25th percentile since there are no Medicaid benchmarks for this measure.
- ◆ Although SCAN Health Care's rate for the *Breast Cancer Screening* measure declined significantly from 2013 to 2014, the rate remained above the national Medicaid 90th percentile (HPL) for the second consecutive year. Additionally, the MCP's rate for the *Osteoporosis Management in Women Who Had a Fracture* measure improved significantly from 2013 to 2014.

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

During the 2013 calendar year, DHCS held contracts with 23 full-scope MCPs and three specialty MCPs to provide health care services to more than 6-million members enrolled in MCMC.³

The DHCS 2014 EAS for the full-scope MCPs consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS[®]) measures developed by the National Committee for Quality Assurance (NCQA) and one measure developed by DHCS and the MCPs, with guidance from the external quality review organization (EQRO), to be used for the statewide collaborative quality improvement project (QIP). The HEDIS data set is a nationally recognized and standardized set of performance measures used by consumers, employers, government agencies, legislators, advocates, and potential purchasers to assess the quality of care provided within an MCP's Medicare, Medicaid, and commercial lines of business.

Several of the 14 HEDIS measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 32. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required EAS measures. The required measures provide information on access to care for women, adolescents, and children; use of imaging studies for low back pain; screening for diseases such as cervical cancer; weight assessment and counseling for nutrition and physical activity for children and adolescents; care provided to members with chronic diseases such as diabetes; hospital readmissions rates; and utilization of outpatient and emergency department care.

In addition to reporting the EAS in 2014, full-scope MCPs were required to report separate rates for their Seniors and Persons with Disabilities (SPD) and non-SPD populations for a selected group of measures using DHCS-identified aid codes. For the *Comprehensive Diabetes Care* hybrid measures, the MCPs were required to use an approved sampling methodology that yielded a valid sample for the SPD and non-SPD populations. The approved sampling methodology is in

³ Medi-Cal Managed Care Enrollment Report, December 2013. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>. Accessed on: June 4, 2014.

Appendix A. A summary of the findings related to the SPD population is included in Section 8 of this report.

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

As part of the EAS, DHCS requires MCPs to undergo an NCQA HEDIS Compliance Audit™⁴ conducted by an EQRO. The EQRO assesses the MCPs' information systems (IS) capabilities and compliance with HEDIS specifications to ensure standardized reporting of performance measure results. For MCPs reporting non-HEDIS measures, the EQRO uses the CMS protocol for validating performance measures.⁵ DHCS contracted with Health Services Advisory Group, Inc. (HSAG), to perform these on-site compliance audits in 2014, analyze MCMC HEDIS and non-HEDIS rates objectively, and evaluate each MCP's current performance level relative to local and national thresholds and benchmarks.

This report presents MCMC HEDIS 2014 results for the 2013 measurement period of January 1, 2013, through December 31, 2013, for all MCPs reporting rates for the measurement period, except Family Mosaic Project. The 2014 results for Family Mosaic Project are for non-HEDIS measures, but are for the same 2013 measurement period as the other MCPs. Additionally, results are presented for the *All-Cause Readmissions* measure, which was developed for the statewide collaborative QIP and is not a HEDIS measure. Full-scope MCP results are included in Section 5 of this report, and specialty MCP results are included in Section 6.

Medi-Cal Managed Care Overview

In the State of California, DHCS administers the Medicaid Program (Medi-Cal) through its fee-for-service (FFS) and managed care delivery systems.

⁴ NCQA HEDIS Compliance Audit™ is a trademark of NCQA.

⁵ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: Feb 19, 2013.

During the 2013 measurement year, DHCS contracted with 23 full-scope MCPs and three specialty MCPs to provide health care services throughout California in all 58 counties. DHCS operates MCMC through a service delivery system that encompasses six models of managed care for its full-scope services: the Two-Plan Model (TPM)—both local initiative (LI) and commercial plan (CP), the Geographic Managed Care (GMC) model, the County Organized Health System (COHS) model, the Regional Model (RM), the Imperial model, and the San Benito model. DHCS monitors MCP performance across model types. Table 2.1 shows participating MCPs by model type.

Table 2.1—Medi-Cal Managed Care Health Plans by Model Type as of December 31, 2013

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

Model Type	MCP Name	Counties
Imperial	Molina Healthcare of California Partner Plan, Inc.	Imperial
	California Health & Wellness	
San Benito	Anthem Blue Cross Partnership Plan	San Benito
Regional	Anthem Blue Cross Partnership Plan	Butte, Colusa, Glenn, Plumas, Sierra, Sutter, Tehama (The rates for these counties will be reported as a single rate and identified as Region 1.)
	California Health & Wellness	
	Anthem Blue Cross Partnership Plan	Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, Yuba (The rates for these counties will be reported as a single rate and identified as Region 2.)
	California Health & Wellness	
Kaiser North	Amador, El Dorado, Placer	
Specialty MCPs	AHF Healthcare Centers	Los Angeles
	Family Mosaic Project	San Francisco
	SCAN Health Plan	Los Angeles, Riverside, San Bernardino

For enrollment information on each county, go to

<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

Medi-Cal Expansion

As part of the expansion authority under Section 1115 of the Social Security Act,⁶ MCMC expanded into several rural Eastern counties of California effective November 1, 2013. Anthem Blue Cross Partnership Plan and California Health & Wellness Plan contracted with DHCS to provide MCMC services for 18 rural counties—Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba. Anthem Blue Cross Partnership Plan also expanded into San Benito County to provide MCMC services, and California Health & Wellness Plan contracted with DHCS to provided MCMC services in Imperial County. Also as part of the expansion authority, Kaiser North contracted with DHCS to provide MCMC services in Amador, El Dorado, and Placer counties beginning November 1, 2013; Molina Healthcare of California Partner Plan, Inc., contracted with DHCS to provide MCMC services in Imperial County beginning September 1, 2013; and Partnership HealthPlan of California contracted with DHCS to provided MCMC services in Del-Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties beginning September 1, 2013.

⁶ Information on Section 1115 of the Social Security Act can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>.

In order to report HEDIS measure rates, MCPs must first have members meet continuous enrollment requirements for each measure being reported, which typically means members need to be enrolled in the MCP for 11 of 12 months during the measurement year. None of the expansion county Medi-Cal members had continuous enrollment during 2013. Consequently, DHCS did not require MCPs operating in these expansion counties to report rates for HEDIS 2014 and HSAG did not include any of the expansion counties in the 2014 NCQA HEDIS Compliance Audits conducted with Anthem Blue Cross Partnership Plan, Kaiser North, Molina Healthcare of California Partner Plan, Inc., and Partnership HealthPlan of California. Additionally, HSAG did not conduct an NCQA HEDIS Compliance Audit™ with California Health & Wellness Plan in 2014 since the MCP began Medi-Cal operations on November 1, 2013. HSAG will include all expansion counties in the 2015 NCQA HEDIS Compliance Audit process, and rates for the expansion counties will be included in the 2015 HEDIS Aggregate Report.

Medi-Cal Managed Care Delivery System

Following are the descriptions of the six MCP model types and the specialty MCPs.

County-Organized Health System

A COHS is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of health care providers. Each COHS MCP is established by the County Board of Supervisors and governed by an independent commission.

Geographic Managed Care

In the GMC model, DHCS allows MCMC beneficiaries to select from several commercial MCPs within a specified geographic area. The GMC model currently operates in San Diego and Sacramento counties.

Imperial

In the Imperial model, DHCS contracts with two CPs to provide MCMC services.

Regional Model (RM)

In Regional model counties, DHCS contracts with two CPs to provide MCMC services.

San Benito

In the San Benito model, there is one CP, and DHCS contracts with the plan. In a San Benito model county, MCMC beneficiaries can choose the MCP or regular (FFS) Medi-Cal.

Two-Plan

In TPM counties, MCMC beneficiaries may choose between two MCPs; typically, one MCP is an LI and the other a CP. DHCS contracts with both plans. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries.

Specialty Managed Care Health Plans

Specialty MCPs provide health care services to specialized populations. During the 2013 measurement period, DHCS held contracts with three specialty MCPs.

How DHCS Uses Performance Measures

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

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

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

Federal requirements mandate the validation of performance measures. DHCS satisfies this federal requirement by contracting with HSAG, an EQRO, to conduct performance measure validation. HSAG follows the CMS protocol for validating performance measures by conducting NCQA HEDIS Compliance Audits for HEDIS measures or using the CMS protocol for validating

performance measures for non-HEDIS measures, ensuring that MCPs report accurate and complete information.

DHCS shares MCP-specific and aggregate HEDIS results with the MCPs and CMS, and releases the results publicly. DHCS also incorporates these results into its consumer guides for new beneficiaries and uses the data as part of its annual performance assessment of MCPs and MCMC as a whole.

In addition, DHCS gives annual quality awards to MCPs in recognition of their accomplishments. The criteria for these awards are based on MCPs' HEDIS results for exceptional performance or marked improvement. HEDIS awards were presented to MCPs at the 2014 Annual Quality Conference, *Health Across the Lifespan—Medi-Cal Managed Care Strategies for Quality Improvement*, held in Sacramento, CA, on September 11, 2014. These awards were based on HEDIS 2014 performance results. The awards were presented as follows:

- ◆ Gold Quality Award—Kaiser North—Sacramento County
- ◆ Silver Quality Award—Kaiser South—San Diego County
- ◆ Bronze Quality Award—San Francisco Health Plan—San Francisco County
- ◆ Honorable Mention Quality Award—Central California Alliance for Health—Monterey/Santa Cruz counties
- ◆ Most Improved Award—Kern Family Health Care—Kern County

Minimum Performance Levels and High Performance Levels

DHCS annually establishes a minimum performance level (MPL) and high performance level (HPL) for each required performance measure except for utilization measures, first-year measures, measures that had significant specification changes impacting comparability, or if DHCS decides to prioritize efforts in other areas of poor performance. To establish the MPLs and HPLs for the 2014 rates, DHCS used the *HEDIS 2013 Audit Means, Percentiles, and Ratios*, which reflect the previous year's benchmarks (CY 2012). The MPLs for the 2014 rates were based on the Medicaid national 25th percentiles, and the HPLs were based on the national Medicaid 90th percentiles. MCPs are contractually required to perform at or above the established MPLs. MCPs that have rates below the MPLs must submit an improvement plan to DHCS outlining the steps they will take to improve care. MCP performance in relation to the MPL and HPL for each measure becomes public record with the release of this report.

For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, the 10th percentile (rather than the 90th percentile) is used for the HPL, and the 75th percentile (rather than the 25th percentile) is used for the MPL because for this measure, a *lower* rate indicates better performance.

The *Colorectal Cancer Screening* measure (reported by AHF Healthcare Centers) and the *Osteoporosis Management in Women Who Had a Fracture* measure (reported by SCAN Health Plan) do not have established national percentiles for the Medicaid population. For comparison purposes, HSAG and DHCS use the established commercial 25th and 90th percentiles for the *Colorectal Cancer Screening* measure and the established Medicare 25th and 90th percentiles for the *Osteoporosis Management in Women Who Had a Fracture* measure.

Auto-Assignment Program

For the 2013 measurement year, five performance measures, selected from the EAS, are part of DHCS's auto-assignment program, along with two measures related to MCP use of safety net providers. DHCS awards more default enrollment (i.e., assignment of members who do not choose an MCP) to TPM and GMC model MCPs that perform high on selected measures and that achieve improvement over time. The auto-assignment program encourages MCPs to improve and/or maintain quality of care and services provided to their members.

The following five performance measures, selected from the EAS, were part of DHCS's auto-assignment program during the 2013 measurement year:

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

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

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

After auto-assignment rates are determined using the EAS and safety net measures, rates are shifted by 5 percent within counties from the higher-cost MCP to the lower-cost MCP. This 5 percent cost factor is determined through a comparison of MCP capitated rates for non-SPD MCP members.

Medi-Cal Managed Care's 2014 Performance Measures

DHCS's 2014 EAS for full-scope MCPs, which used 2013 measurement year data, included the following measures:

- ◆ *All-Cause Readmissions* (statewide collaborative QIP measure)—SPD stratification required
- ◆ *Ambulatory Care*—SPD stratification required
 - *Emergency Department Visits*
 - *Outpatient Visits*
- ◆ *Annual Monitoring for Patients on Persistent Medications*—SPD stratification required
 - *ACE Inhibitors or ARBs*
 - *Digoxin*
 - *Diuretics*
- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- ◆ *Cervical Cancer Screening*
- ◆ *Childhood Immunization Status—Combination 3*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners*—SPD stratification required
 - *12 to 24 Months*
 - *25 Months to 6 Years*
 - *7 to 11 Years*
 - *12 to 19 Years*
- ◆ *Comprehensive Diabetes Care*—SPD stratification required
 - *Blood Pressure Control (<140/90 mm Hg)*
 - *Eye Exam (Retinal) Performed*
 - *HbA1c Testing*
 - *HbA1c Control (<8.0 Percent)*
 - *HbA1c Poor Control (>9.0 Percent)*
 - *LDL-C Control (<100 mg/dL)*
 - *LDL-C Screening*
 - *Medical Attention for Nephropathy*
- ◆ *Controlling High Blood Pressure*
- ◆ *Immunizations for Adolescents—Combination 1*
- ◆ *Medication Management for People with Asthma*

- *Medication Compliance 50% Total*
- *Medication Compliance 75% Total*
- ◆ *Prenatal and Postpartum Care*
 - *Postpartum Care*
 - *Timeliness of Prenatal Care*
- ◆ *Use of Imaging Studies for Low Back Pain*
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents*
 - *BMI Assessment: Total*
 - *Nutrition Counseling: Total*
 - *Physical Activity Counseling: Total*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Measures for the specialty MCPs included the following:

AHF Healthcare Centers

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

Family Mosaic Project (non-HEDIS measures)

- ◆ *School Attendance*
- ◆ *Out-of-Home Placements*

SCAN Health Plan

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

About HEDIS

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

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

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

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

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

How HEDIS Results Are Calculated and Displayed

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

Methodology

To assist health plans in standardized reporting, NCQA develops and makes available technical specifications that provide information on how to collect data for each measure, with general guidelines for sampling and calculating rates. DHCS’s EAS requirements for 2014 indicate that MCPs are responsible for adhering to the *HEDIS 2014 Technical Specifications, Volume 2*.

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

The HEDIS process begins well in advance of the MCPs reporting their rates. MCPs typically calculated their 2014 HEDIS rates with measurement data from January 1, 2013, to December 31, 2013, with the exception of some measures that deviate slightly from this measurement period. Performance measure calculation and reporting typically involves three phases: Off-site, On-site, and Post-on-site.⁷

Off-site Activity (October through March)

- ◆ MCPs prepare for data collection and the on-site audit.
- ◆ MCPs complete the HEDIS Record of Administration, Data Management, and Processes (Roadmap), a tool used by MCPs to communicate information to the auditor about the MCPs' systems for collecting and processing data for HEDIS.
- ◆ The EQRO conducts kick-off calls with MCPs to provide guidance on HEDIS audit processes and to ensure MCPs are aware of important deadlines.
- ◆ The EQRO reviews the MCPs' completed Roadmaps to assess compliance with the audit standards and provides MCPs with an IS standard tracking report that lists outstanding items and areas that require additional clarification.
- ◆ The EQRO reviews the MCPs' source code used for calculating the EAS measures to ensure compliance with the technical specifications, unless the MCPs use a vendor whose measures are certified by NCQA.
- ◆ The MCPs prepare for medical record review validation for EAS measures that require the hybrid method for data collection.
- ◆ The EQRO conducts supplemental data validation for all supplemental data sources the MCPs intend to use for reporting.
- ◆ The EQRO conducts preliminary rate review to assess the MCPs' data completeness and accuracy early in the audit process.

⁷ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: Feb 19, 2013

On-site Activity (January through April)

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

Post-on-site Activity (May through October)

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

Data Collection Methodology

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

Administrative Method

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

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

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

*A specialty MCP measure

The administrative method is cost-efficient, but it can produce lower rates due to incomplete data submission (often by capitated providers), as well as data that are typically not submitted as part of a claims or encounter submission such as Current Procedural Terminology (CPT) II codes, or as a result of global billing practices.

Hybrid Method

The hybrid method requires health 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. Health plans use administrative data to identify services provided to those members. When administrative data do not show evidence that a service was provided, health plans then review medical records for those members.

The hybrid method generally produces higher rates but is considerably more labor-intensive. For example, a health plan that has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure may use the hybrid method. After randomly selecting 411 eligible members, the 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 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 health plan finds that 4,000 of the 10,000 members had evidence of a postpartum visit using only administrative data, the final rate for this measure would be $4,000/10,000$, or 40 percent.

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

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

* A specialty MCP measure

** A full-scope MCP and specialty MCP measure

MCPs that have complete and robust administrative data may choose to report measures using only the administrative method and avoid labor-intensive medical record review; however, currently only two of the MCMC-contracted MCPs report rates in this manner, Kaiser North and Kaiser South. The Kaiser MCPs have IS capabilities, primarily due to their closed-system model and electronic medical records that support administrative-only reporting because medical record review does not generally yield additional data beyond what the MCP had already captured administratively.

Inclusion of Dual Eligible Population

Following are the guidelines for MCPs regarding inclusion of dual eligible members in their Medi-Cal performance measure rates:

- ◆ If an MCP does not have the Medicare product, then the MCP would not have dual eligible members to include in its rates.
- ◆ If the member has both Medicare and Medicaid benefits through the MCP, then the member is included in the Medi-Cal rates.
- ◆ If the member has Medicare FFS or Medicare through another MCP, then the member can be excluded from the Medi-Cal rates.

HEDIS Aggregate Report Data Displays

This report displays 2014 HEDIS results relative to both local and national performance thresholds and benchmarks to compare the quality of services provided to MCMC beneficiaries. A comparison of performance gives both DHCS and the MCPs a framework to identify opportunities to improve care.

While the specific rates are not included in this report, comparisons are made to the 2013 national Medicaid and national commercial averages as reported by NCQA. The objectives and goals of the federal Healthy People 2020 program provide another source of national benchmarks for comparison within this report, as available.⁸ Local benchmarks include prior-year MCMC weighted averages. MCPs' submission of HEDIS data provides rates calculated to the sixth decimal place. Unless otherwise noted, results in this report are rounded to the second decimal place to be consistent with the display of comparative local and national benchmarks. Some rounded rates may appear the same; however, the more precise rates are not identical.

⁸ Healthy People 2020 is managed by the U.S. Department of Health and Human Services' Office of Prevention and Health Promotion. Healthy People 2020 provides a framework for prevention for the nation by establishing national health objectives and setting national goals to reduce threats. Available at <http://www.healthypeople.gov/2020/default.aspx>. Accessed on: August 16, 2014.

Medi-Cal Managed Care Weighted Averages

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

HSAG computed the 2014 MCMC weighted average for each measure using MCP-reported rates and weighted these by each MCP's reported eligible population size for the measure. Rates that were given an audit result of *Not Reportable* were not included in the calculation of these averages. A weighted average is a better estimate of care for all MCMC beneficiaries than a straight average of MCMC MCPs' performance.

Significance Testing

HSAG used a Chi-square test to determine if MCP-specific differences between 2013 and 2014 rates were statistically significant. The Chi-square test was used to judge how likely it is that the difference is real and not the result of chance.

To determine significance for this report, HSAG used the traditionally accepted risk level of 0.05 (i.e., probability of a Type I error). At this risk level, the probability of finding a statistically significant difference between the 2013 and 2014 rates when a true difference does not exist is not more than 5 percent.

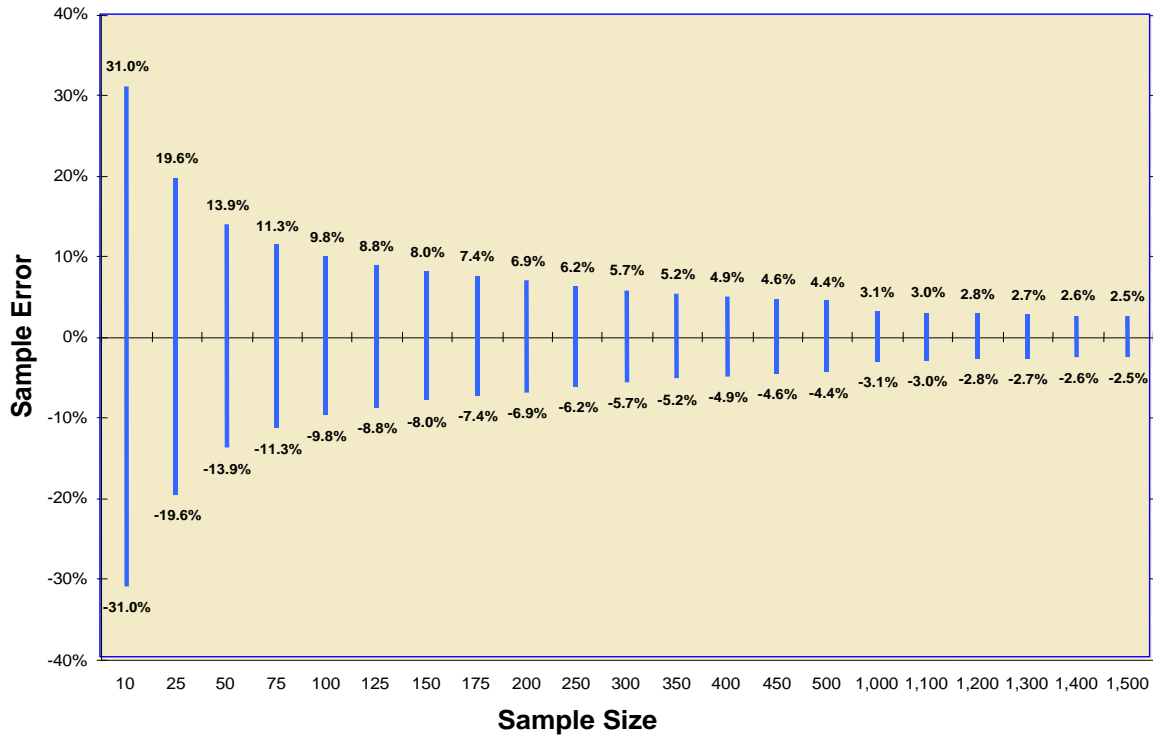
Understanding Sampling Error and Effect Size

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

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

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

Figure 3.1—Relationship of Sample Size to Sample Error



Effect Size

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

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

The general guidelines to determine effect size are:

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

The HEDIS sample sizes have already considered the effect size. The sampling formula used by HEDIS is sufficient to detect a difference of 10 percentage points. According to the *HEDIS 2014 Technical Specifications, Volume 2*, “This was chosen because it is a big enough difference to be actionable, it is not a burden 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 = 0.05, 80 percent power) and a normal approximation to the binomial with a continuity correction factor also employed.

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

How to Interpret Results

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

Considerations for Data Interpretation

1. How accurate are the results?
2. How do MCMC rates compare to national percentiles?
3. How are MCMC MCPs performing overall?

Results Accuracy

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

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

To prevent such ambiguity, this report uses a standardized methodology that requires the reported rate to be at or above the threshold level to be considered as meeting the target. For internal

purposes, MCPs should understand and consider the issue of sampling error when implementing interventions.

Comparing Medi-Cal Managed Care Rates to National Benchmarks

This report displays the MCMC weighted average for each measure and compares it to the following national benchmarks:

- ◆ National Medicaid 25th Percentile—all measures except the *All-Cause Readmissions* and *HbA1c Poor Control (>9.0 Percent)*. The *All-Cause Readmissions* measure is not compared to national benchmarks because it is a statewide collaborative QIP measure and not a HEDIS measure and the *HbA1c Poor Control (>9.0 Percent)* measure is compared to the national Medicaid 75th percentile because a higher rate indicates worse performance for this measure.
- ◆ National Medicaid 90th Percentile—all measures except the *All-Cause Readmissions* and *HbA1c Poor Control (>9.0 Percent)*. The *All-Cause Readmissions* measure is not compared to national benchmarks because it is a statewide collaborative QIP measure and not a HEDIS measure and the *HbA1c Poor Control (>9.0 Percent)* measure is compared to the national Medicaid 10th percentile because a lower rate indicates better performance for this measure.
- ◆ National Medicaid Average—all measures except the *All-Cause Readmissions* measure because it is a statewide collaborative QIP measure and not a HEDIS measure.
- ◆ National Commercial Average—all measures except the *All-Cause Readmissions* measure because it is a statewide collaborative QIP measure and not a HEDIS measure.
- ◆ Healthy People 2020—for measures with a comparable Healthy People 2020 goal.

Note: The MCMC weighted averages presented for each HEDIS reporting year are compared to benchmarks developed using prior year's rates. For example, MCMC weighted averages reported for HEDIS 2014, representing calendar year 2013 data, are compared to the national HEDIS 2013 benchmarks, representing calendar year 2012 data.

Medi-Cal Managed Care Health Plans' Overall Performance

As indicated in the Introduction section, DHCS establishes performance thresholds annually for minimum performance and high performance except for utilization measures, first-year measures, measures that had significant specifications changes impacting comparability, or if DHCS decides to prioritize efforts in other areas of poor performance. This report displays each MCP's rate relative to the established MPL and HPL for each measure, with the highest threshold or rate at the top of the chart, continuing in descending order to the lowest threshold or rate. Using NCQA's *HEDIS 2013 Audit Means, Percentiles, and Ratios*, DHCS established MPLs and HPLs for its HEDIS 2014 EAS. DHCS based the MPLs on the 2013 Medicaid national 25th percentile and the HPLs on the 2013 Medicaid national 90th percentile, which represent the most recent data available from NCQA at the time this report was prepared.

Also as indicated in the Introduction section, for most measures in this report, the national Medicaid 90th percentile indicates the HPLs and the 25th national Medicaid percentile represents the MPLs. This means that Medi-Cal MCPs with reported rates above the 90th percentile (HPL) rank in the top 10 percent of all Medicaid plans nationwide. Similarly, MCPs reporting rates below the 25th percentile (MPL) rank in the bottom 25 percent nationwide for that measure. This differs for one measure, *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*, where lower rates of poor control indicate better care. For this measure, the 10th percentile (rather than the 90th percentile) represents the HPL, and the 75th percentile (rather than the 25th percentile) represents the MPL because a *lower* rate indicates better performance.

The *Colorectal Cancer Screening* measure (reported by AHF Healthcare Centers) and the *Osteoporosis Management in Women Who Had a Fracture* measure (reported by SCAN Health Plan) do not have established national percentiles for the Medicaid population. For comparison purposes, HSAG and DHCS use the established commercial 25th and 90th percentiles for the *Colorectal Cancer Screening* measure and the established Medicare 25th and 90th percentiles for the *Osteoporosis Management in Women Who Had a Fracture* measure.

Performance Trend Analysis

In Appendix B, the “2013–14 Rate Difference” column shows, by measure, a comparison between the HEDIS 2013 results and the HEDIS 2014 results for each MCP. HSAG used a Chi-square test to calculate the statistical significance between MCP rates in 2013 and 2014. The following symbols are used to show statistically significant changes:

- ↑ Rates in 2014 were significantly higher than they were in 2013.
- ↓ Rates in 2014 were significantly lower than they were in 2013.
- ↔ Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲ ▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant *increase* in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 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.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

About Performance Measure Validation

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

To comply with this requirement, DHCS contracted with HSAG to conduct validation of the selected EAS performance measures. HSAG conducted audits in accordance with the 2014 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased.

The IS standards include:

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

HEDIS Audit Results

Through the audit process, HSAG assigns each measure one of the four audit results. A numeric result, usually accompanied with an “R” (*Reportable*), indicates that the MCP complied with all HEDIS specifications to produce an unbiased, reportable rate or rates that can be released for public reporting. Although an MCP may have complied with all applicable specifications, if the MCP's denominator is too small to report (less than 30), the audit result is “NA,” denoting *Small Denominator*. An audit result of “NR” (*Not Reportable*) indicates that the rate should not be publicly reported because the measure deviated from HEDIS specifications enough to bias the reported

rate significantly or that the MCP chose not to report the measure. An “NB” (*Benefit Not Offered*) audit result indicates that the MCP did not offer the benefit required to report the measure.

HEDIS Reporting Capabilities

Key Findings

Twenty-five contracted MCPs underwent performance measure validation. Twenty-four of the MCPs had an NCQA HEDIS Compliance Audit. Family Mosaic Project, a specialty MCP, reported non-HEDIS measures; therefore, it underwent a performance measure validation audit consistent with the CMS protocol for conducting performance measure validation.

All 25 MCP audits were conducted by an NCQA Certified HEDIS Compliance Auditor for the HEDIS 2014 reporting year. Of the 25 audited MCPs, 22 used vendors to calculate and produce rates, and all of these software vendors achieved full measure certification status by NCQA for the reported HEDIS measures. For Family Mosaic Project and the two MCPs that used source code created in-house for measure calculation, HSAG reviewed and approved the source code. HSAG also reviewed and approved the source code, either internal or vendor created, for 23 MCPs for the *All-Cause Readmissions* statewide collaborative QIP measure.

Strengths

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

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

The majority of MCPs are capturing a large volume of data electronically, which reduces the burden of medical record abstraction.

Challenges

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

A few MCPs still receive paper claims and continue to be challenged in convincing some providers to submit electronic versus paper claims.

Recommendations

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

- ◆ Ensure that the rendering provider detail is included on all submitted claims and encounters, especially for services performed at multispecialty and group practices. Inclusion of the rendering provider is important for measures that require a specific provider specialty, such as the identification of a PCP for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, *Weight Assessment and Counseling for Nutrition and Physical Activity*, and *Children and Adolescent's Access to Primary Care Practitioners*; and for the identification of a nephrologist, optometrist, and ophthalmologist for the *Comprehensive Diabetes Care* measures. Improving capture of the rendering provider can decrease the burden of medical record review for measures that allow for hybrid reporting.
- ◆ Focus on obtaining more complete and accurate administrative data and decreasing the use of supplemental databases (due to changes with nonstandard supplemental database requirements). In lieu of standard supplemental data or administrative data, medical record review is preferable to augment hybrid measures, rather than nonstandard databases. The requirements for nonstandard databases are now more stringent than for medical record review, and failure to follow the requirements could invalidate the nonstandard database.
- ◆ Closely monitor timelines, milestones, and deliverables of contracted providers and software vendors. MCPs should consider implementing sanctions for vendors that do not meet contractual requirements.
- ◆ Review Roadmap responses provided by the vendor as well as the MCP's Roadmap to be certain that the process reflected is comprehensive and accurate.
- ◆ Improve reporting accountability by clearly documenting the internal data audit processes.
- ◆ Coordinate the HEDIS rate review quality assurance process with the vendor to ensure accuracy of the rates produced periodically by the vendor.
- ◆ Document in detail any changes in software, vendor, or any testing or implementation process.

All-Cause Readmissions

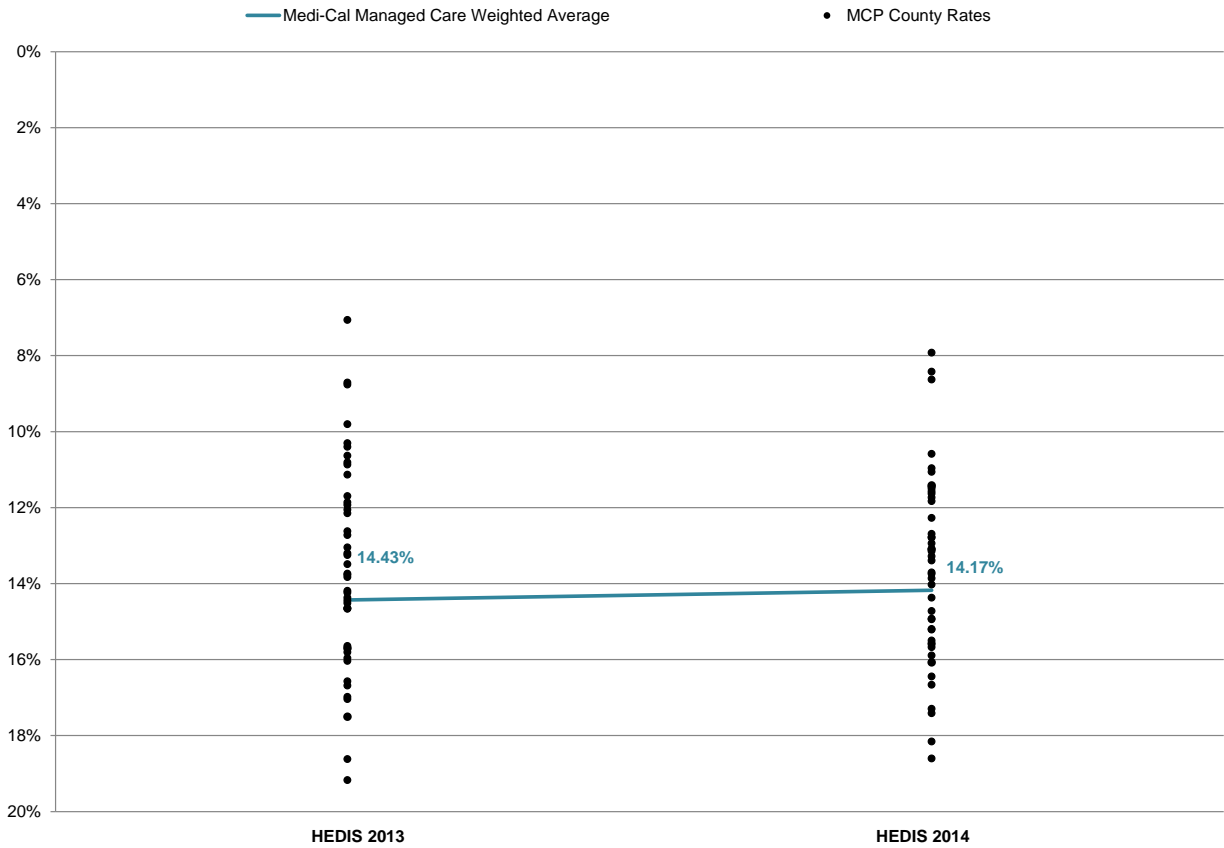
Measure Definition

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

Importance

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

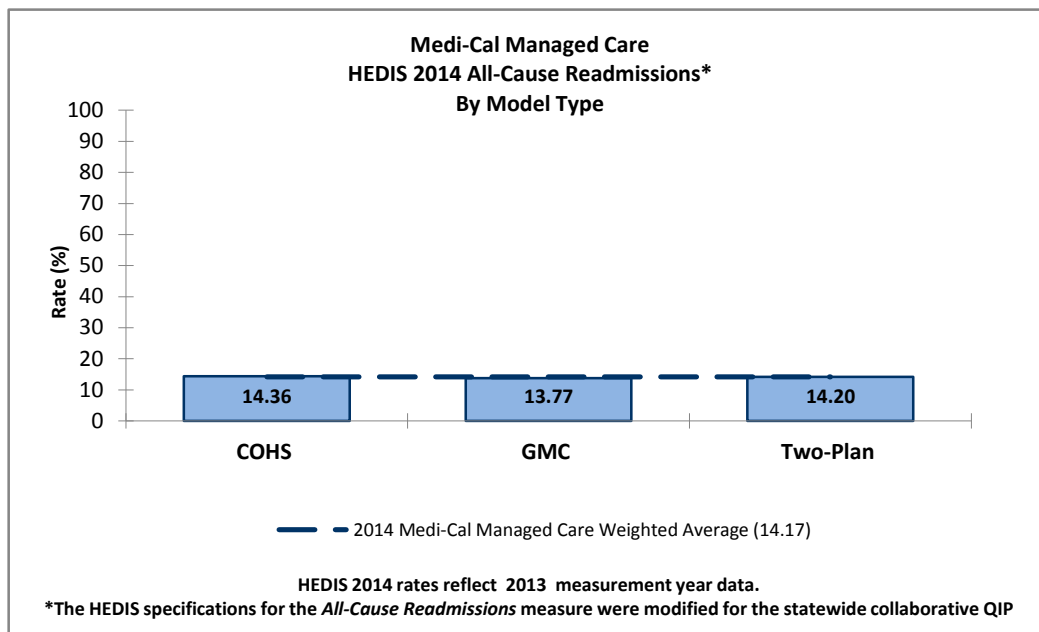
Performance Results—All-Cause Readmissions*



* This measure is a non-HEDIS measure used for the ACR Collaborative QIP; therefore, no Minimum Performance Level or High Performance Level is established for this measure.

Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 All-Cause Readmissions



This measure is a non-HEDIS measure used for the ACR Collaborative QIP; therefore, no Minimum Performance Level or High Performance Level is established for this measure.

Summary of Results—All-Cause Readmissions

DHCS did not establish an MPL or HPL for the *All-Cause Readmissions* measure, so no comparisons to an MPL or HPL have been made.

The MCMC weighted average improved by less than one-half of a percentage point from 2013 to 2014. The COHS model, TPM, and GMC model performed similarly.

High and Low Performers

The *All-Cause Readmissions* rates for six MCP counties declined (i.e., improved) significantly from 2013 to 2014, and the readmissions rates for six MCP counties increased significantly from 2013 to 2014.

Best and Emerging Practices—All-Cause Readmissions

In order to reduce the number of hospital readmissions, interventions should address discharge planning, transitions of care processes, care coordination, education, and self-management. The Institute for Healthcare Improvement (IHI) provides information on 15 promising interventions. Following are descriptions of four interventions that have strong evidence of reducing hospital readmissions based on randomized controlled trials or program evaluations:⁹

Project Re-Engineered Discharge¹⁰

Boston University Medical Center developed Project Re-Engineered Discharge (RED), a process for improved discharge coordination. The project is located at an urban hospital that serves a low-income, ethnically diverse population. The intervention components are facilitated by a discharge advocate, a specially trained nurse who does the following:

- ◆ Educates patients about their diagnosis throughout their hospital stay.
- ◆ Makes appointments for clinician follow-up, test result follow-up, and post-discharge testing.
- ◆ Organizes post-discharge services.
- ◆ Confirms medication plans with patients.
- ◆ Reconciles the discharge plans with national guidelines and clinical pathways.

⁹ Institute for Healthcare Improvement. Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions. March 2009. Available at: http://ah.cms-plus.com/files/STAAR_A_Compendium_of_Promising_Interventions.pdf. Accessed on: August 14, 2014.

¹⁰ Jack BW, Veerappa KC, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization. *Ann Intern Med.* 2009;150:178-187. Quoted by: Institute for Healthcare Improvement. Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions. March 2009. Available at: http://ah.cms-plus.com/files/STAAR_A_Compendium_of_Promising_Interventions.pdf. Page 3. Accessed on: August 14, 2014.

- ◆ Gives patients a written discharge plan and assesses their understanding of the plan.
- ◆ Reviews with the patients what to do if a problem arises.
- ◆ Expedites transmission of the discharge summary to outpatient providers.
- ◆ Calls patients two-to-three days after discharge to reinforce the discharge plan and offer problem-solving.

The intervention resulted in a significant reduction in hospital utilization and was found to be most effective for patients with higher rates of hospital utilization in the preceding six months.

Transitional Care Model^{11,12}

The University of Pennsylvania School of Nursing created and tested the Transitional Care Model, which uses advanced practice nurses to provide pre- and post-discharge coordination of care for high-risk, elderly patients with chronic illness. Some Medi-Cal MCPs are implementing this intervention to reduce readmissions. The core components of the program include:

- ◆ Consistency of providers across the entire episode of care, with the transitional care nurse as the primary coordinator of care.
- ◆ In-hospital assessment and development of an evidence-based plan of care.
- ◆ Regular home visits with the provision of ongoing telephone support (24 hours per day, seven days per week) for an average follow-up period of two months post-discharge.
- ◆ Comprehensive, holistic focus on each patient's needs, including the reason for the primary hospitalization and other complicating or coexisting events.
- ◆ Emphasis on early identification and response to health care risks and symptoms, and avoidance of adverse events that lead to readmissions.
- ◆ Active engagement of patients, their families, and informal caregivers, including providing education and support.
- ◆ Communication to, between, and among the patient, family, informal caregivers, and health care providers and professionals.

¹¹ Naylor MD, Brooten DA, Campell RL, Maislin G, McCauley KM, Schwartz JS. Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial. *J Am Geriatr Soc.* 2004;52:675-684. Quoted by: Institute for Healthcare Improvement. *Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions.* March 2009. Available at: http://ah.cms-plus.com/files/STAAR_A_Compendium_of_Promising_Interventions.pdf. Page 4. Accessed on: August 14, 2014.

¹² Naylor MD, Brooten D, Campbell R, et al. Comprehensive discharge planning and home follow-up of hospitalized elders: a randomized clinical trial. *JAMA.* 1999; 281:613-620. Quoted by: Institute for Healthcare Improvement. *Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions.* March 2009. Available at: http://ah.cms-plus.com/files/STAAR_A_Compendium_of_Promising_Interventions.pdf. Page 4. Accessed on: August 14, 2014.

Two randomized controlled trials showed that the use of the Transitional Care Model results in fewer rehospitalizations, lower overall health care costs, and improved patient satisfaction.

Care Transitions Program^{13,14,15}

Eric Coleman, MD, MPH, developed the Care Transitions Program, a four-week intervention focusing on improving care transitions by fostering improved self-management skills. Several Medi-Cal MCPs are implementing this program to reduce hospital readmissions. The four main components of the Care Transitions Program are:

- ◆ Medication self-management.
- ◆ Patient-centered medical record.
- ◆ Follow-up with a physician.
- ◆ Knowledge of “red flags” or warning signs/symptoms and how to respond.

The Care Transitions Program is designed for community-dwelling patients aged 65 and older and centers on the use of a transition coach who is a nurse or nurse practitioner. The transition coach conducts a home visit within 72 hours of discharge and speaks with the patient by telephone two, seven, and 14 days post-discharge. During the telephone calls, the transition coach prepares the patient for upcoming provider visits, helps the patient reconcile or identify discrepancies in medications, encourages follow-up, and serves as a single point of contact.

One evaluation of the program found that patients who participated in the Care Transitions Program were significantly less likely to be rehospitalized than patients who did not participate in the intervention, at 30, 90, and 180 days after discharge. Additionally, the time to rehospitalization was significantly longer for those participating in the Care Transitions Program.

¹³ Coleman EA, Smith JD, Frank JC, Min S, Parry C, Kramer AM. Preparing patients and caregivers to participate in care delivered across settings: the care transitions intervention. *J Am Geriatr Soc.* 2004;52(11):1817-1825. Quoted by: Institute for Healthcare Improvement. *Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions.* March 2009. Available at: http://ah.cms-plus.com/files/STAAR_A_Compendium_of_Promising_Interventions.pdf. Page 5. Accessed on: August 14, 2014.

¹⁴ Coleman EA. CMS Learning Session: The Care Transitions Intervention. December 20, 2007 [presentation]. Available at: www.cfmc.org/caretransitions/learning_sessions.htm. Quoted by: Institute for Healthcare Improvement. *Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions.* March 2009. Available at: http://ah.cms-plus.com/files/STAAR_A_Compendium_of_Promising_Interventions.pdf. Page 5. Accessed on: August 14, 2014.

¹⁵ http://www.innovativecaremodels.com/care_models/12. Quoted by: Institute for Healthcare Improvement. *Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions.* March 2009. Available at: http://ah.cms-plus.com/files/STAAR_A_Compendium_of_Promising_Interventions.pdf. Page 5. Accessed on: August 14, 2014.

Evercare Care Model^{16,17}

Evercare is one of the nation's largest health care coordination programs for people who have long-term or advanced illness, who are older, or have disabilities. The core elements of the intervention are:

- ◆ Enhanced primary care and care coordination by nurse practitioners or care managers.
- ◆ Nurse practitioner care in the nursing home setting.
- ◆ Development and coordination of personalized care plans with all health care providers.

Evercare's services are triaged according to four levels of care intensity based on patients' health and functional status. Results showed that hospitalizations were reduced by 45 percent, emergency room visits were reduced by 50 percent, and cost savings were realized.

¹⁶ Kane RL, Keckhafer G, Flood S, Bershady B, Siadaty MS. The effect of Evercare on hospital use. *J Am Geriatr Soc*. 2003 Oct;51(10):1427-34. Quoted by: Institute for Healthcare Improvement. *Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions*. March 2009. Available at: http://ah.cms-plus.com/files/STAAR_A_Compendium_of_Promising_Interventions.pdf. Page 6. Accessed on: August 14, 2014.

¹⁷ http://www.innovativecaremodels.com/care_models/17/results. Quoted by: Institute for Healthcare Improvement. *Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions*. March 2009. Available at: http://ah.cms-plus.com/files/STAAR_A_Compendium_of_Promising_Interventions.pdf. Page 6. Accessed on: August 14, 2014.

Annual Monitoring for Patients on Persistent Medications

Measure Definition

The *Annual Monitoring for Patients on Persistent Medications* measure assesses the percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, rates are reported separately.

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

Importance

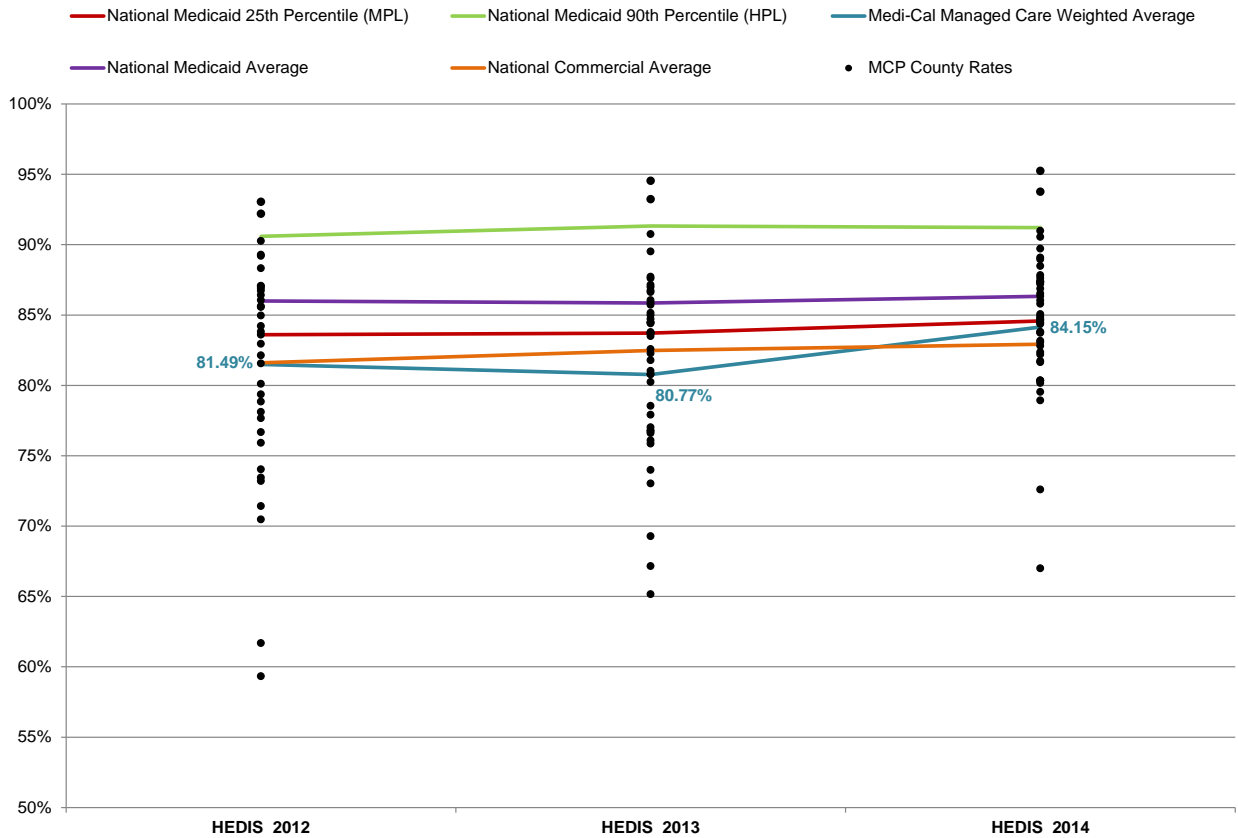
Patient safety is highly important, especially for patients at increased risk of adverse medication events from long-term medication use. Persistent use of these medications warrants monitoring and follow-up by the prescribing provider to assess for side-effects and adjust medication dosage accordingly.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

The costs of annual monitoring are offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications. According to the Agency for Healthcare Research and Quality, total costs of medication-related problems due to misuse of medications in the ambulatory setting has been estimated to exceed \$76 billion annually.¹⁸

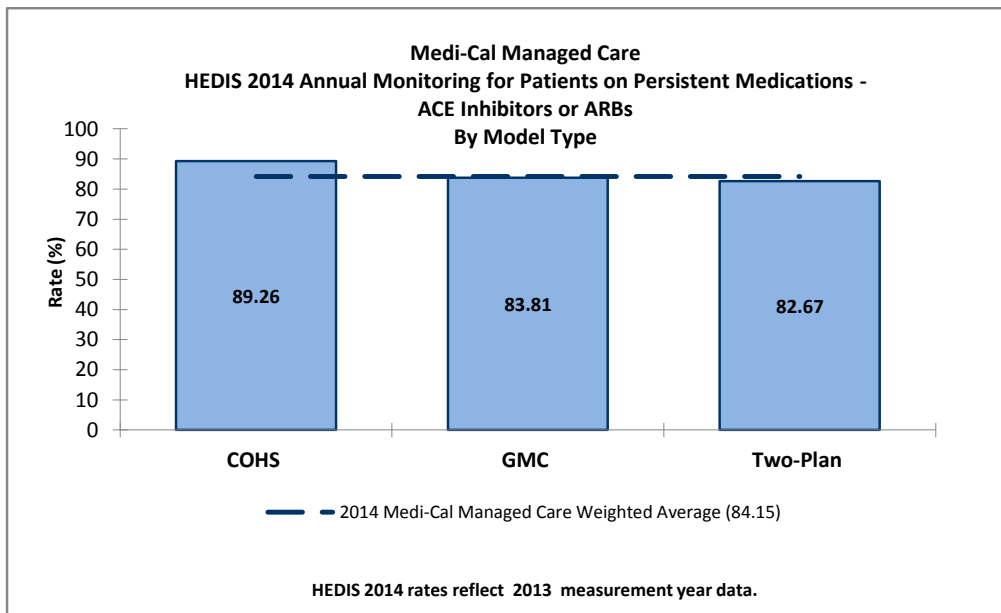
Appropriate monitoring of medication therapy remains a significant issue to guide therapeutic decision making and provides largely unmet opportunities for improvement in care for patients on persistent medications.

¹⁸ Johnson JA, Bootman JL, Arch Intern Med. 1995 Oct 9;155(18):1949-56.

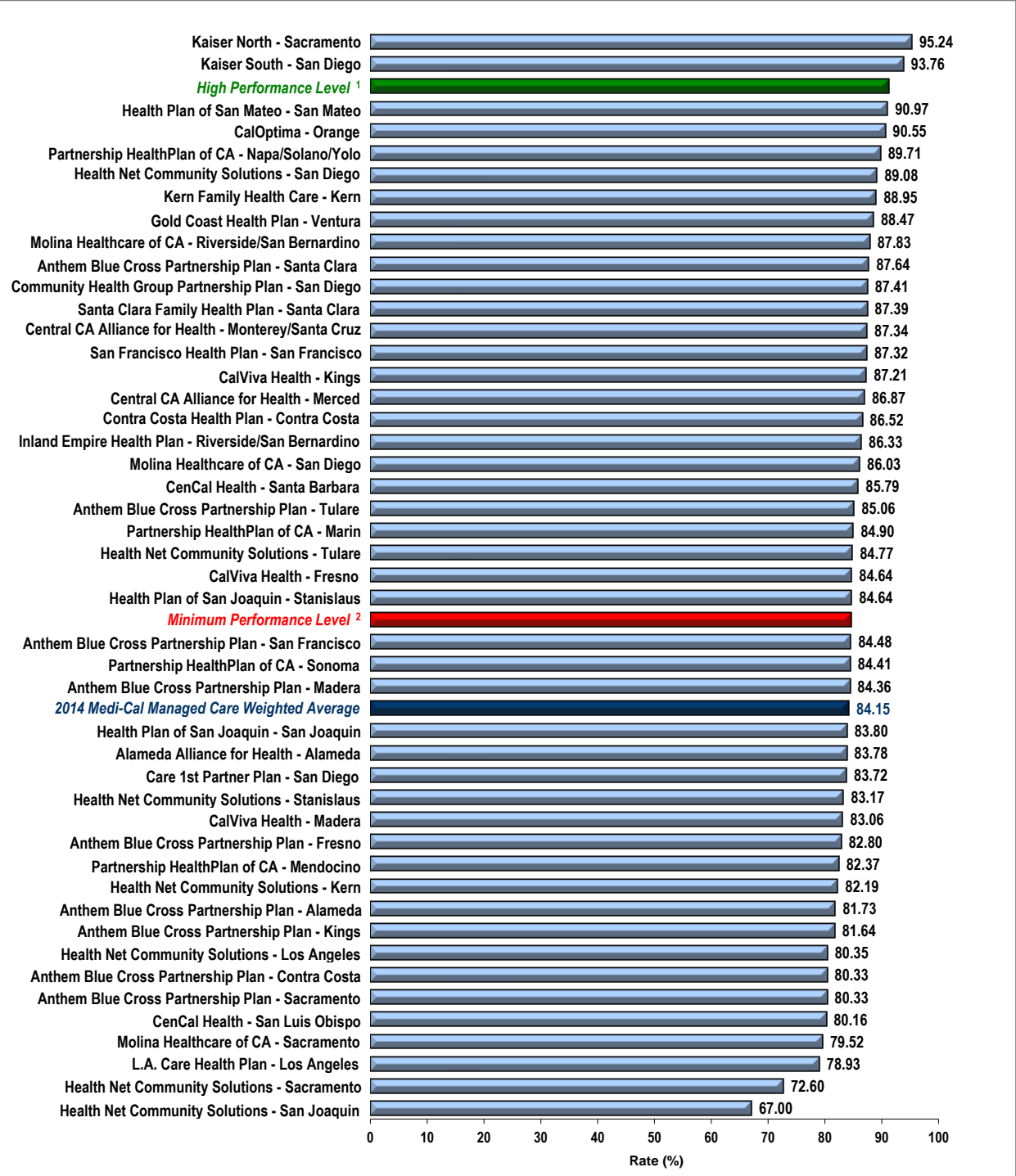
Performance Results—Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs



Note:
 ♦ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
 ♦ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
 ♦ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.
² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.
 Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs

Although the MCMC weighted average for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure improved by more than 3 percentage points from 2013, for the third consecutive year, the MCMC weighted average was below the national Medicaid 25th percentile (MPL) and national Medicaid average for this measure. While the HEDIS 2013 MCMC weighted average was lower than the national commercial average, the HEDIS 2014 rate was slightly higher than the national commercial average. For the third consecutive year, the COHS model performed better than the TPM and GMC model.

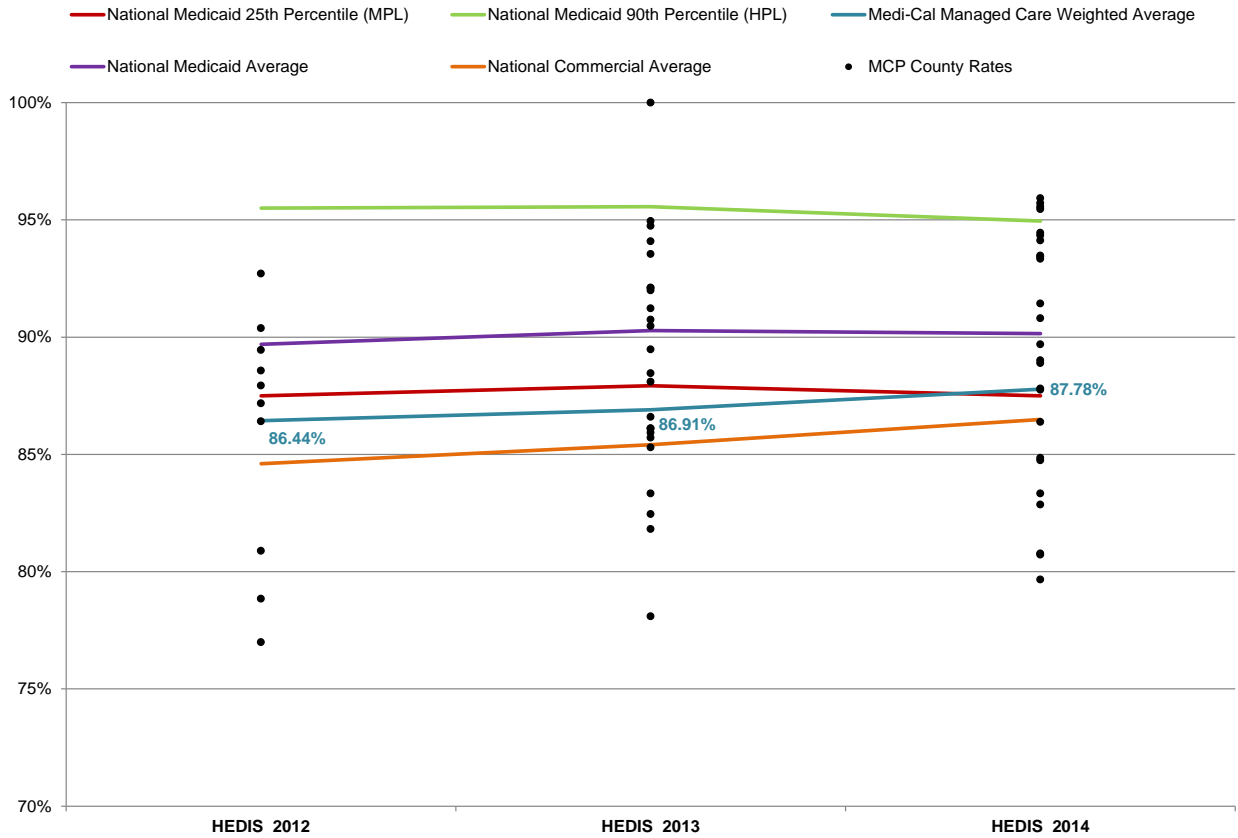
High and Low Performers

Since being required to report this measure in 2012, Kaiser North—Sacramento County and Kaiser South—San Diego County have had rates above the national Medicaid 90th percentile (HPL) for this measure. The rates for 19 MCP counties improved significantly from 2013 to 2014, and zero rates declined significantly from 2013 to 2014.

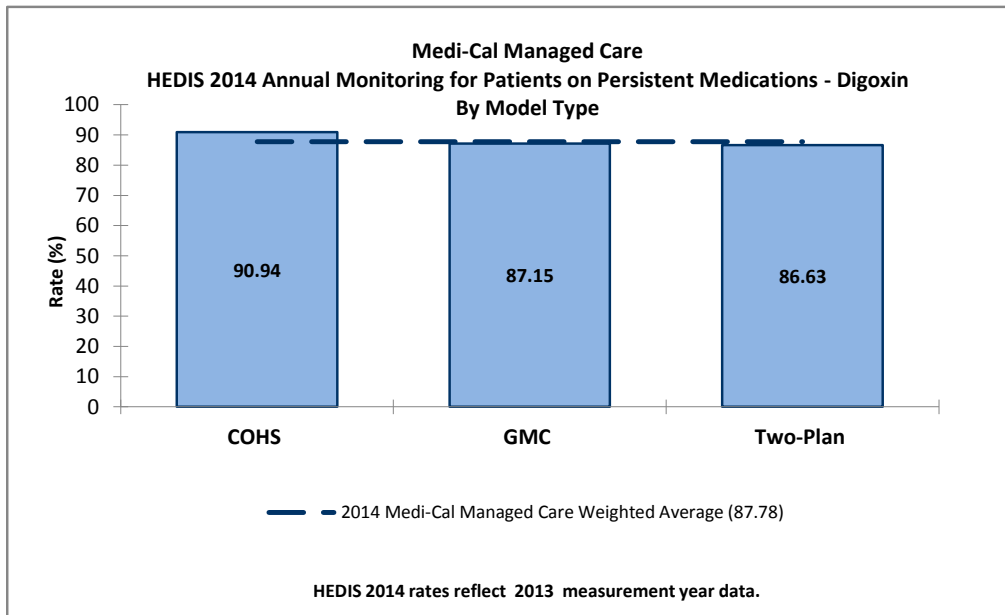
Twenty-one MCP county rates were below the MPL in 2014. Seven MCP counties had rates below the MPL in 2013 that improved to above the MPL in 2014, and four MCP counties had rates that moved from being above the MPL in 2013 to below the MPL in 2014. The rates for 11 MCP counties were below the MPL for the third consecutive year; however, DHCS only held the MCPs accountable to meet the MPL for 2013 and 2014.

Note: The rate for Health Net Community Solutions—San Joaquin County was one of the 21 rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL.

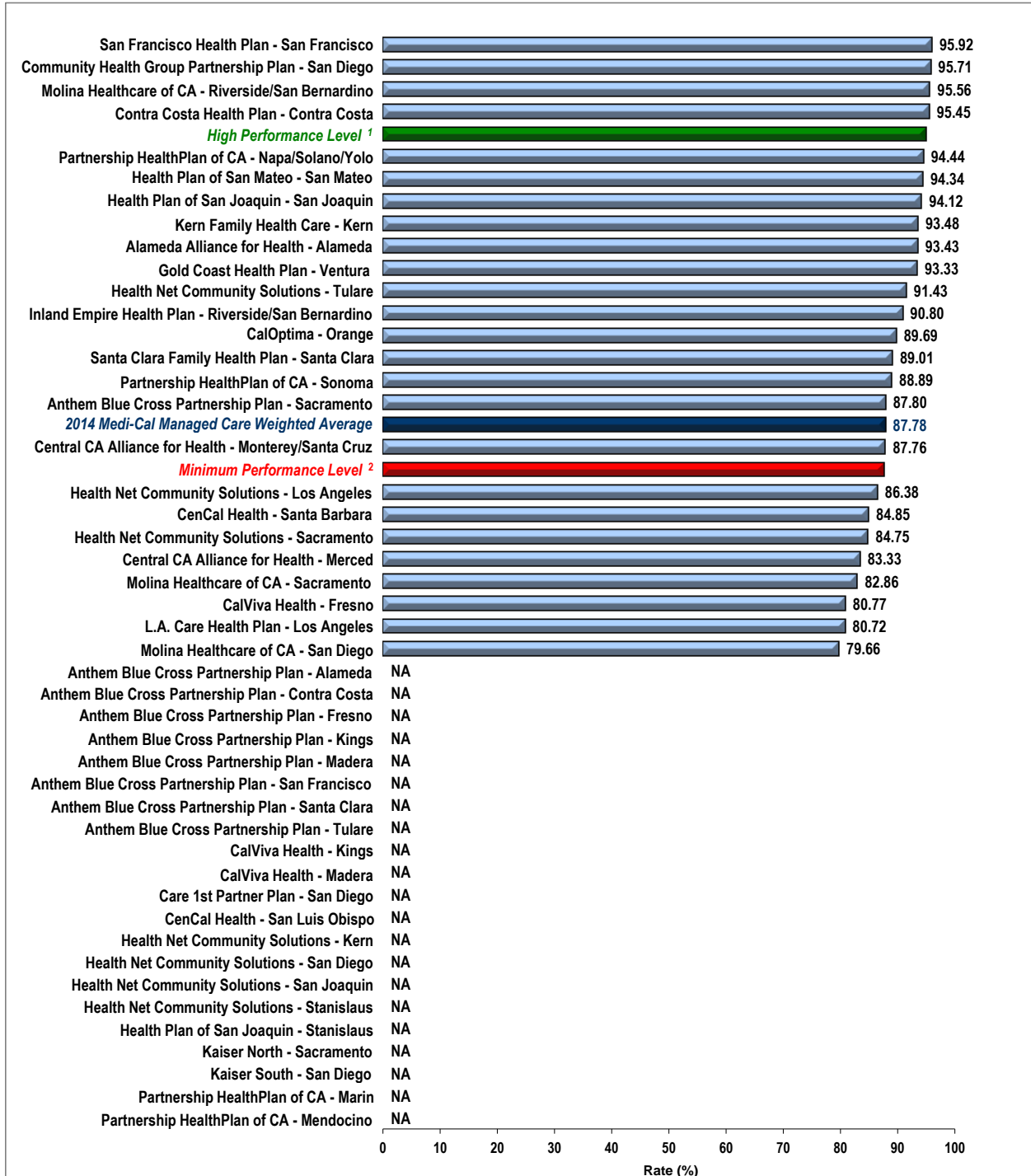
Performance Results—Annual Monitoring for Patients on Persistent Medications—Digoxin



Note:
 ♦ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
 ♦ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
 ♦ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Annual Monitoring for Patients on Persistent Medications—Digoxin



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.
² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.
 NA = A Not Applicable audit finding because the MCP's denominator was too small (i.e., less than 30).
 Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results— Annual Monitoring for Patients on Persistent Medications—Digoxin

The MCMC weighted average for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure improved from below the national Medicaid 25th percentile (MPL) in 2013 to above the MPL in 2014. For the third consecutive year, the MCMC weighted average was higher than the national commercial average and lower than the national Medicaid average. Consistent with 2013, the COHS model performed better than the TPM and GMC model.

High and Low Performers

Four MCP county rates were above the national Medicaid 90th percentile (HPL):

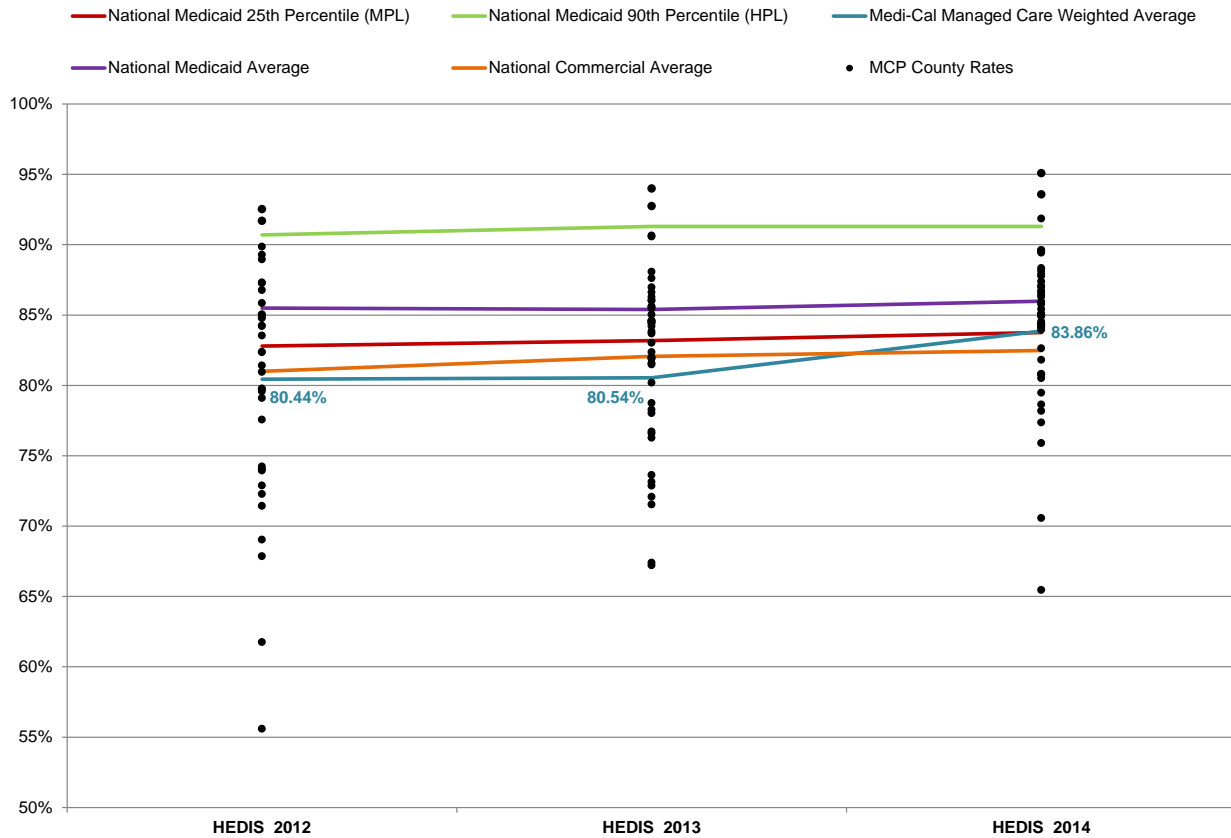
- ◆ Contra Costa Health Plan—Contra Costa County
- ◆ Community Health Group Partnership Plan—San Diego County
- ◆ Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino counties
- ◆ San Francisco Health Plan—San Francisco County

Eight MCP county rates were below the MPL for this measure, and 21 MCP counties had an audit result of “NA” for this measure, meaning that although the MCP complied with all applicable specifications, it had a denominator less than 30 for the measure, resulting in the “NA” audit result.

The rates for Contra Costa—Contra Costa County and San Francisco Health Plan—San Francisco County were below the MPL in 2013, and the MCPs were able to move the rates from below the MPL in 2013 to above the HPL in 2014. Partnership HealthPlan of California—Sonoma County and Anthem Blue Cross Partnership Plan—Sacramento County were able to move their rates from below the MPL in 2013 to above the MPL in 2014. The rate for Molina Healthcare of California Partner Plan, Inc.—San Diego County was above the MPL in 2013; however, the rate declined significantly from 2013 to 2014, resulting in the rate being below the MPL in 2014.

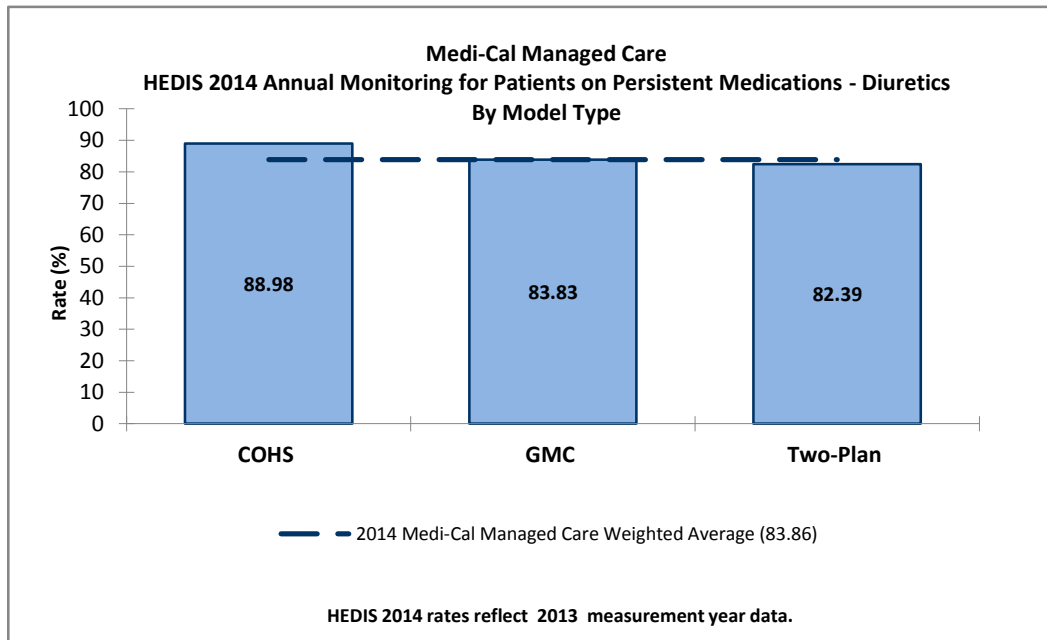
The rates for Health Net Community Solutions, Inc.—Los Angeles County and L.A. Care—Los Angeles County were below the MPL for the third consecutive year; however, DHCS only held the MCPs accountable to meet the MPL for 2013 and 2014.

Performance Results—Annual Monitoring for Patients on Persistent Medications—Diuretics

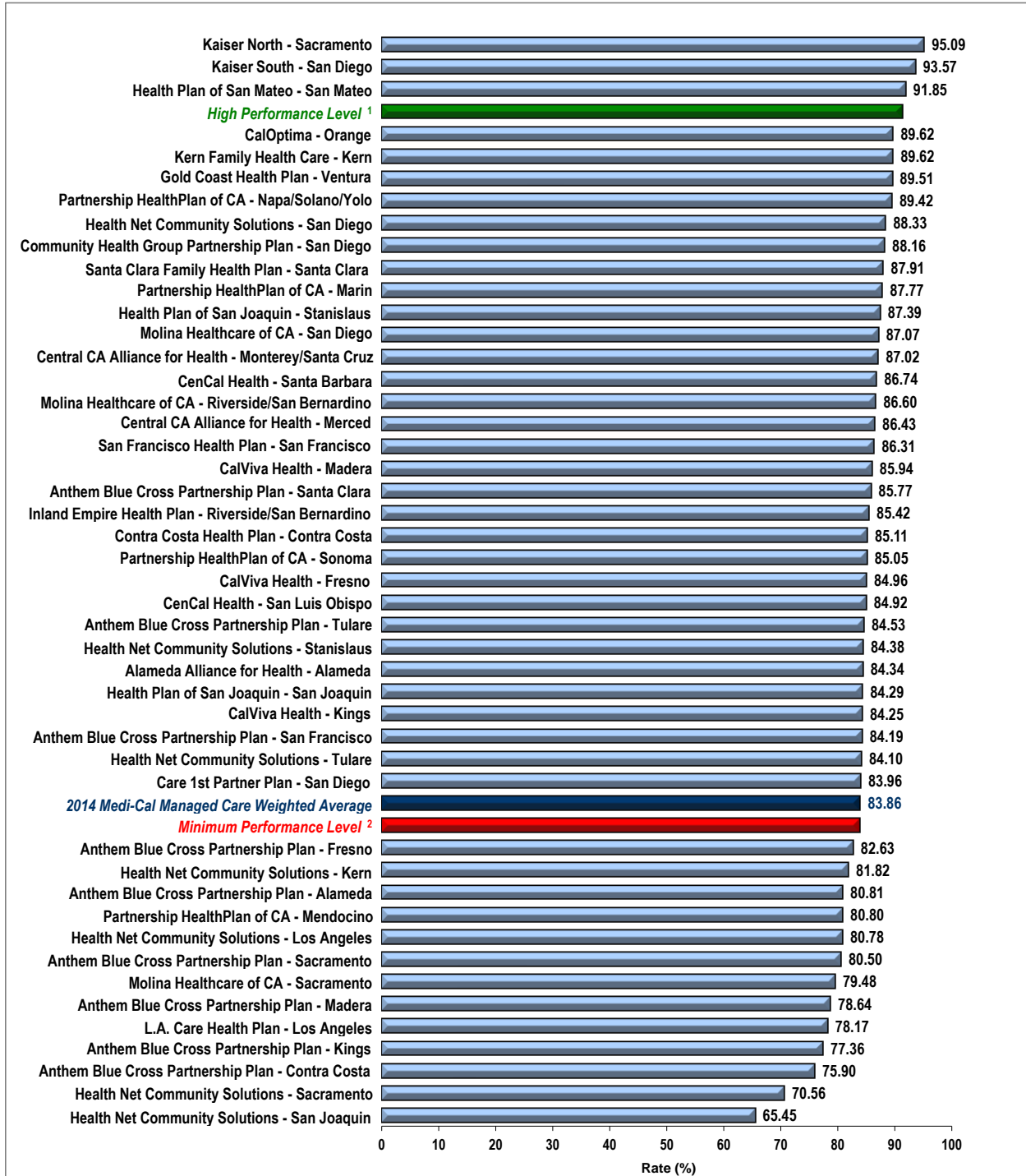


Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Annual Monitoring for Patients on Persistent Medications—Diuretics



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.
² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.
 Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Annual Monitoring for Patients on Persistent Medications—Diuretics

The MCMC weighted average for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure improved from below the national Medicaid 25th percentile (MPL) in 2013 to above the MPL in 2014. The rate also improved from below the national commercial average for this measure in 2013 to above the commercial average in 2014. The rate remained below the national Medicaid average for this measure for the third consecutive year. Consistent with 2013, the COHS model performed better than the TPM and GMC model.

High and Low Performers

Since being required to report this measure in 2012, Kaiser North—Sacramento County and Kaiser South—San Diego County have had rates above the national Medicaid 90th percentile (HPL) for this measure. Additionally, the rate for Health Plan of San Mateo—San Mateo County was above the HPL in 2014.

The rates for 13 MCP counties were below the MPL for this measure in 2014 compared to 22 in 2013. The rates for 11 MCP counties improved from below the MPL in 2013 to above the MPL in 2014, and two rates moved from above the MPL in 2013 to below the MPL in 2014. The rates for 16 MCP counties improved significantly from 2013 to 2014, and no rates declined significantly from 2013 to 2014.

Note: The rate for Health Net Community Solutions—San Joaquin County was one of the 13 rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL.

The rates for eight MCP counties were below the MPL for the third consecutive year; however, DHCS only held the MCPs accountable to meet the MPL for 2013 and 2014.

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

Provider Education

Patients who take medications for chronic conditions may be at increased risk for adverse drug effects or problems relating to nonadherence. While yearly testing for patients on medications such as angiotensin-converting enzyme inhibitors (ACE inhibitors), statins, and anticonvulsants to monitor blood levels and organ functioning is essential, blood tests cannot replace good communication between providers and members. Educational interventions for providers should include prescribing products that simplify the medication regimen or the practice of sending refill

reminders. Although these interventions are less effective than direct patient contact, they are often more cost-effective.¹⁹

Computerized Methods to Detect Adverse Drug Events

Use of computerized data to identify adverse drug events (ADEs) is one strategy to monitor the effects prescribed medications are having on patients. The Food and Drug Administration and The Joint Commission emphasize the need for reporting ADEs as important markers of the quality of medical care. Additionally, the American Society for Health-Systems Pharmacists recommends that all health care systems develop ongoing ADE reporting programs. Compared with manual chart review, use of electronic medical records to estimate the rate of ADEs is faster and much less expensive.²⁰

¹⁹ A. A. Petrilla, J. S. Benner, D. S. Battleman, et al. Evidence-based interventions to improve patient compliance with antihypertensive and lipid-lowering medications. 2005. *International Journal of Clinical Practice*. 59:12; 1141–1451.

²⁰ Honigman B, Lee J, Rothschild J, et al. Using Computerized Data to Identify Adverse Drug Events in Outpatients. *J Am Med Inform Assoc*. 2001 May–Jun; 8(3): 254–266.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Measure Definition

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

Importance

While only about 5 percent of adults report an episode of acute bronchitis each year, 90 percent seek treatment.²¹ Acute bronchitis consistently ranks among the top 10 conditions that account for the most ambulatory office visits to U.S. physicians. The majority of acute bronchitis cases (more than 90 percent) have a nonbacterial cause (i.e., are viral in origin) making the prescribing of antibiotics for the treatment of acute bronchitis inappropriate.

Although prescribing antibiotics for acute bronchitis is inappropriate, between 1996 and 2010, antibiotic prescribing for acute bronchitis was 71 percent and the prescribing rate increased during the time period.²² The prescribing of antibiotics for smokers with acute bronchitis is even greater. More than 90 percent of smokers with acute bronchitis receive antibiotics; however, there is no evidence that smokers are in greater need of antibiotics than nonsmokers.²³

When the treatment of acute bronchitis was compared between patients who received an antibiotic and patients who received a placebo, it was found that there were few benefits in terms of reducing impairments such as coughing, sore throat, sputum build-up, and fever. Antibiotic use did, however, show a significantly higher level of adverse medication side effects such as nausea, vomiting, headaches, and rash.²⁴ Use of unnecessary antibiotics can lead to unwanted side effects such as “diarrhea, rashes, nausea, and stomach pain.”²⁵ Although hospitals have seen a reduction in the misuse of antibiotics, doctors in the community continue to overprescribe antibiotics at the request of their patients. By prescribing unnecessary antibiotics, physicians are adding to the creation of “superbugs” and the public health threat that “superbugs” create.²⁶

²¹ National Committee for Quality Assurance. *The State of Health Care Quality 2013*. Washington, D.C: NCQA 2013.

²² Barnett, Michael L., MD and Linder, Jeffrey A., MD, MPH, Antibiotic Prescribing for Adults With Acute Bronchitis in the United States, 1996–2010, *JAMA*, May 21, 2014, Volume 311, Number 19.

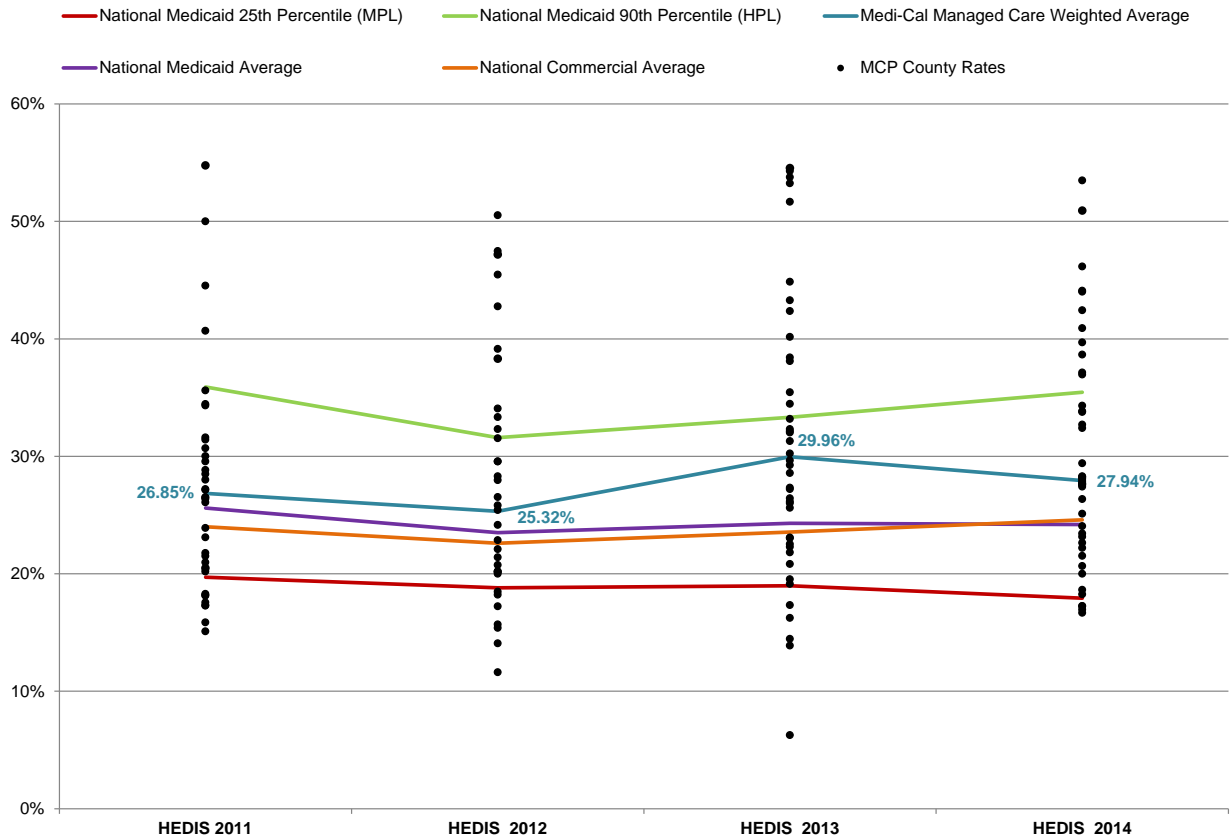
²³ Braman SS. Chronic Cough Due to Acute Bronchitis: ACCP Evidence-Based Clinical Practice Guidelines. *Chest*. 2006; 129; 95S–103S.

²⁴ Chandran R. Should We Prescribe Antibiotics for Acute Bronchitis? *American Family Physician*. 2001.

²⁵ Get Smart: Know When Antibiotics Work, Bronchitis, September 30, 2013. Centers for Disease Control. Available at <http://www.cdc.gov/getsmart/antibiotic-use/uri/bronchitis.html>. Accessed on June 10, 2014.

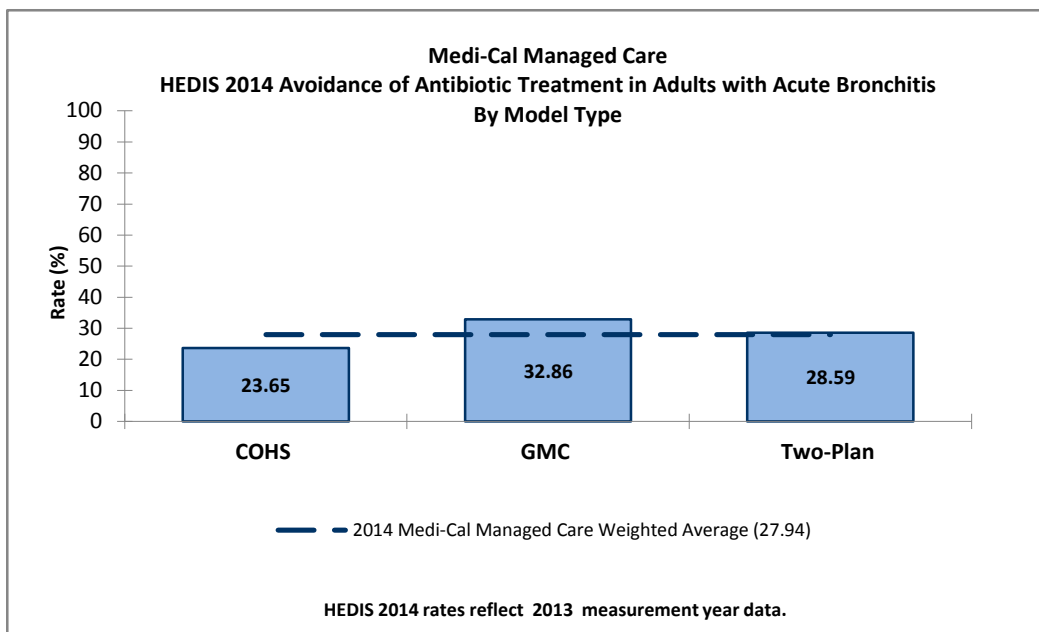
²⁶ Antibiotics Drastically Overprescribed for Sore Throats, Bronchitis, October 4, 2013. Science Daily. Available at <http://www.sciencedaily.com/releases/2013/10/131004105256.htm>. Accessed on June 10, 2014.

Performance Results—Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

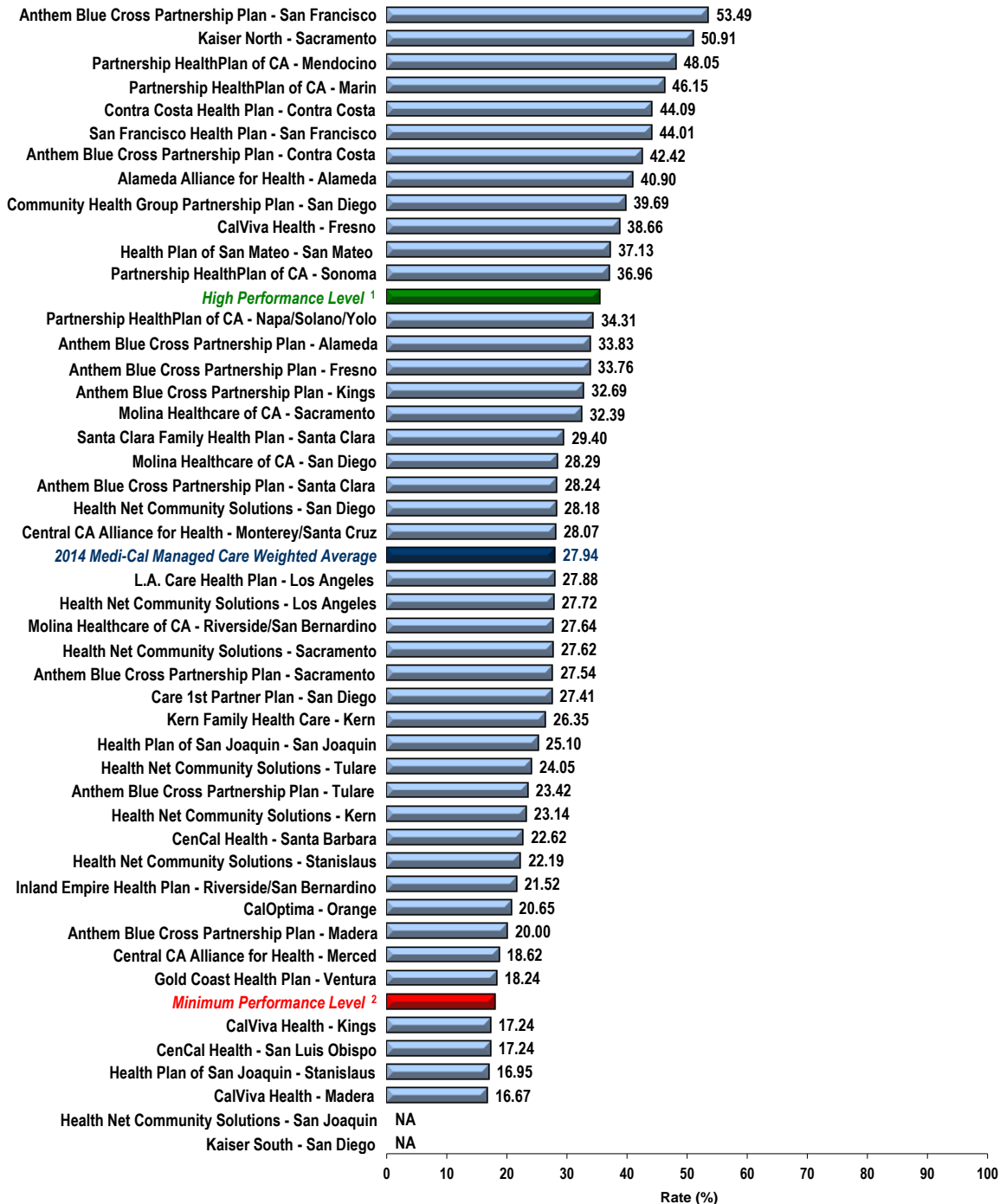


Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
HEDIS 2014 Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

NA = A Not Applicable audit finding because the MCP's denominator was too small (i.e., less than 30).

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results

Although the MCMC weighted average for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure declined by more than 2 percentage points from 2013 to 2014, the rate remained higher than the national Medicaid 25th percentile (MPL), and national Medicaid and commercial averages for the fourth consecutive year. The rate remained below the national Medicaid 90th percentile (HPL). The GMC model performed better than the TPM and COHS model.

High and Low Performers

The rates for 12 MCP counties exceeded the HPL compared to four rates that were below the MPL. Two MCP counties had an audit result of “NA” for this measure, meaning that although the MCPs complied with all applicable specifications, they had a denominator less than 30 for the measure, resulting in the “NA” audit result.

Note: The rate for Health Plan of San Joaquin—Stanislaus County was one of the four rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL.

Four MCP counties were able to improve their rates for this measure from below the MPL in 2013 to above the MPL in 2014:

- ◆ Anthem Blue Cross Partnership Plan—Madera County (Note: 2013 was the first year the MCP reported a rate for Madera County so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).
- ◆ Central California Alliance for Health—Merced County
- ◆ Gold Coast Health Plan—Ventura County (Note: 2013 was the first year Gold Coast Health Plan reported a rate for Ventura County so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).
- ◆ Molina Healthcare of California Partner Plan, Inc.—San Diego County

CalViva Health saw a decline in its rates for Kings and Madera counties from 2013 to 2014. Although the decline was not statistically significant, the change resulted in the rates moving from above the MPL in 2013 to below the MPL in 2014. (Note: 2013 was the first year CalViva Health reported rates for Kings and Madera counties, so DHCS did not hold the MCP accountable to meet the MPL for these counties in 2013).

The rates for the following four MCP counties improved significantly from 2013 to 2014:

- ◆ Community Health Group Partnership Plan—San Diego County, resulting in the rate being above the HPL for 2014

- ◆ Molina Healthcare of California Partner Plan, Inc.—Sacramento County and San Diego County
- ◆ Partnership HealthPlan of California—Mendocino County

The rates for four Health Net Community Solutions, Inc. counties—Los Angeles, Sacramento, San Diego, and Stanislaus—declined significantly from 2013 to 2014. Additionally, the following MCP counties had rates that declined significantly from 2013 to 2014:

- ◆ Health Plan of San Joaquin—San Joaquin County
- ◆ L.A. Care Health Plan—Los Angeles County
- ◆ San Francisco Health Plan—San Francisco County

Although the rate for San Francisco Health Plan—San Francisco County declined significantly, the rate remained above the HPL for 2014.

The rates for the following MCP counties have been above the HPL for four consecutive years:

- ◆ Anthem Blue Cross Partnership Plan—San Francisco County
- ◆ Kaiser North—Sacramento County
- ◆ San Francisco Health Plan—San Francisco County

The rate for Health Plan of San Mateo—San Mateo County has been above the HPL for three consecutive years.

Best and Emerging Practices—Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

The overuse of antibiotics has created “superbugs.” In order to prevent the further development of these “superbugs,” antibiotics should not be used to treat acute bronchitis. It has been shown that providing education directly to the patient at the time of the visit is more effective than educational efforts involving pamphlets or newsletters.²⁷ MCPs and other organizations are developing interventions to help educate both the patient and the provider.

In order to help providers determine when it is appropriate to provide antibiotics for acute bronchitis, the University of Pennsylvania, the University of California at San Francisco, and the Geisinger Health Systems developed an algorithm. The algorithm utilizes a patient’s vital signs and chest examination to determine if the patient is a low, intermediate, or high probability case in

²⁷ Ranji, S.R., Steinman, M.A., Shojania, K.G., et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Volume 4—Antibiotic Prescribing Behavior. Technical Review 9.4 2006. AHRQ Publication No. 04(06)-0051-4. Available at: <http://www.ncbi.nlm.nih.gov/books/NBK43956/>. Accessed on: August 16, 2014.

need of antibiotics. Once the patient has been categorized, specific treatment strategies are implemented in order to treat the patient.²⁸

The Get Smart Campaign, developed by Centers for Disease Control and Prevention (CDC), helps educate patients and providers on the appropriate use of antibiotics. CDC provides printed, online, and radio/television materials for patients and providers in both English and Spanish.²⁹ In 2008, CDC established Get Smart About Antibiotics Week, which is an annual effort to coordinate the work of the Get Smart Campaign, state-based appropriate antibiotic use campaigns, non-profit partners, and for-profit partners during a one-week observance of antibiotic resistance and the importance of appropriate antibiotic use.³⁰

²⁸ National Committee for Quality Assurance. An Algorithm to Improve Appropriate Antibiotic Use for Patients with Acute Bronchitis. April 2011. Available at: http://www.ncqa.org/portals/0/Education/An_Algorithm_To_Improve_Appropriate_Antibiotic_Use_for_Bronchitis_Archived_Manual.pdf. Accessed on: August 6, 2014.

²⁹ Centers for Disease Control and Prevention: Get Smart: Know When Antibiotics Work. Available at: <http://www.cdc.gov/getsmart/>. Accessed on: August 6, 2014.

³⁰ Centers for Disease Control and Prevention: Get Smart: Know When Antibiotics Work. Available at: <http://www.cdc.gov/getsmart/campaign-materials/week/overview.html>. Accessed on: August 6, 2014.

Cervical Cancer Screening

Measure Definition

The *Cervical Cancer Screening* measure reports the percentage of women 21 through 64 years of age who were screened for cervical cancer using either of the following criteria:

- ◆ Women age 21–64 who had cervical cytology performed every 3 years.
- ◆ Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Importance

In the United States during 2012, the American Cancer Society estimated 12,170 new cases of invasive cervical cancer and 4,220 deaths resulting from cervical cancer.³¹ In the United States, Hispanic women are most likely to get cervical cancer, followed by African-Americans, Asians and Pacific Islanders, and Whites.³²

A well-proven way to prevent cervical cancer is to have testing (screening) to find pre-cancers before they can turn into invasive cancer. The Pap test (or Pap smear) is the most common way to do this. If a pre-cancer is found it can be treated, stopping cervical cancer before it starts. The five-year relative survival rate for early stages of invasive cervical cancer is 93 percent.³³

In March 2012, the U.S. Preventive Services Task Force (USPSTF) updated the screening guidelines for cervical cancer.³⁴ Consistent with prior recommendations, the 2012 updated guidelines recommend that women aged 21–65 who have a cervix have a Pap smear every three years. The new recommendations provide the alternative of having a combination of Pap smear and HPV testing every five years for women aged 30–65 who want to be screened less frequently. USPSTF did not change its recommendation against cervical cancer screening using HPV testing, alone or with cytology, in women younger than 30.

³¹ American Cancer Society. Cancer Facts and Figures 2012. Available at:

<http://www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-031941.pdf>

Accessed on: September 10, 2013.

³² American Cancer Society. Detailed Guide: Cervical Cancer. Updated 2012. Available at:

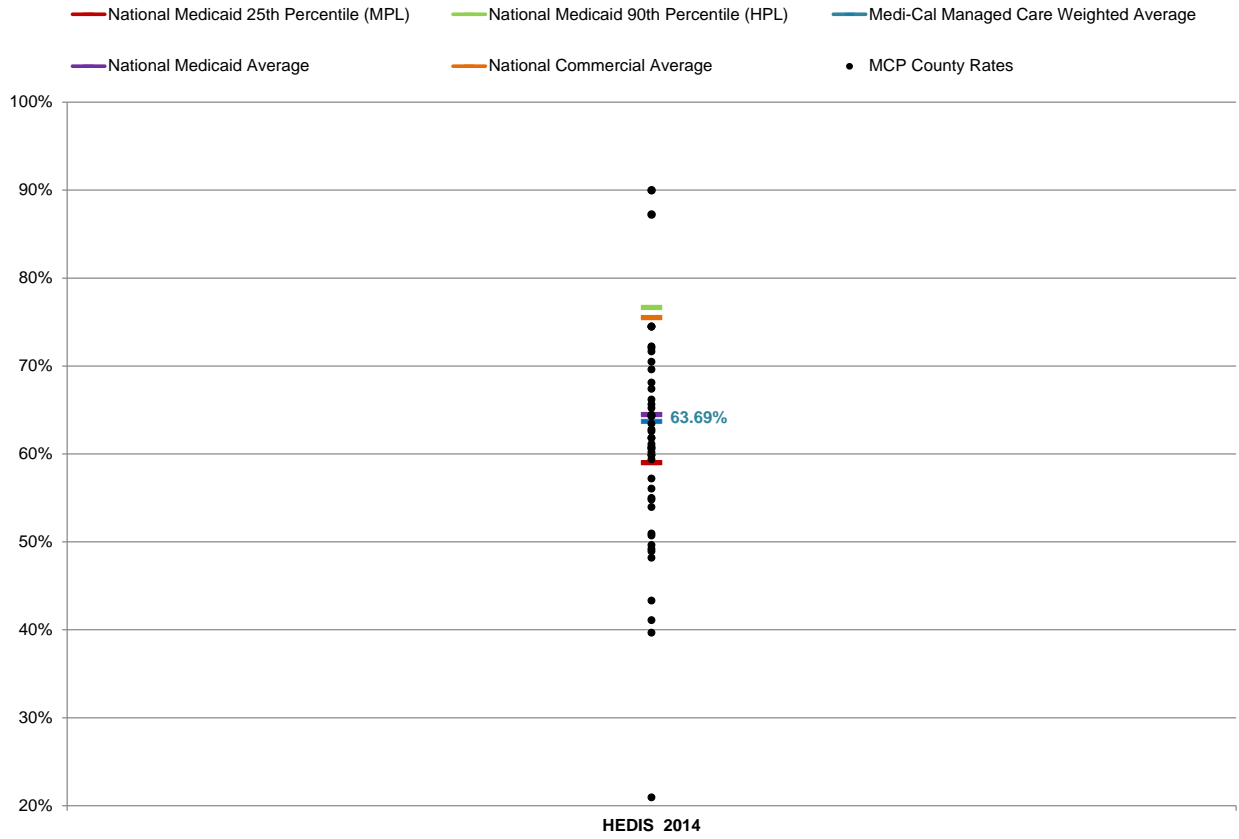
<http://www.cancer.org/acs/groups/cid/documents/webcontent/003094-pdf.pdf>. Accessed on: September 10, 2013.

³³ Ibid.

³⁴ Screening for Cervical Cancer, Topic Page. April 2012. U.S. Preventive Services Task Force. Available at:

<http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm>. Accessed on: October 30, 2013.

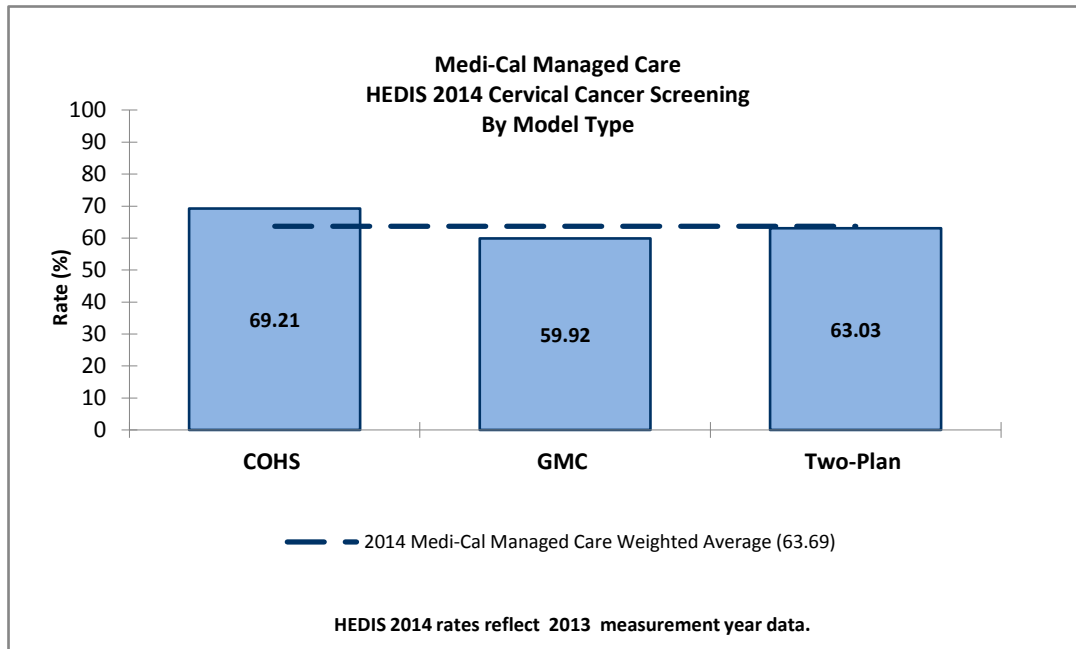
Performance Results—Cervical Cancer Screening



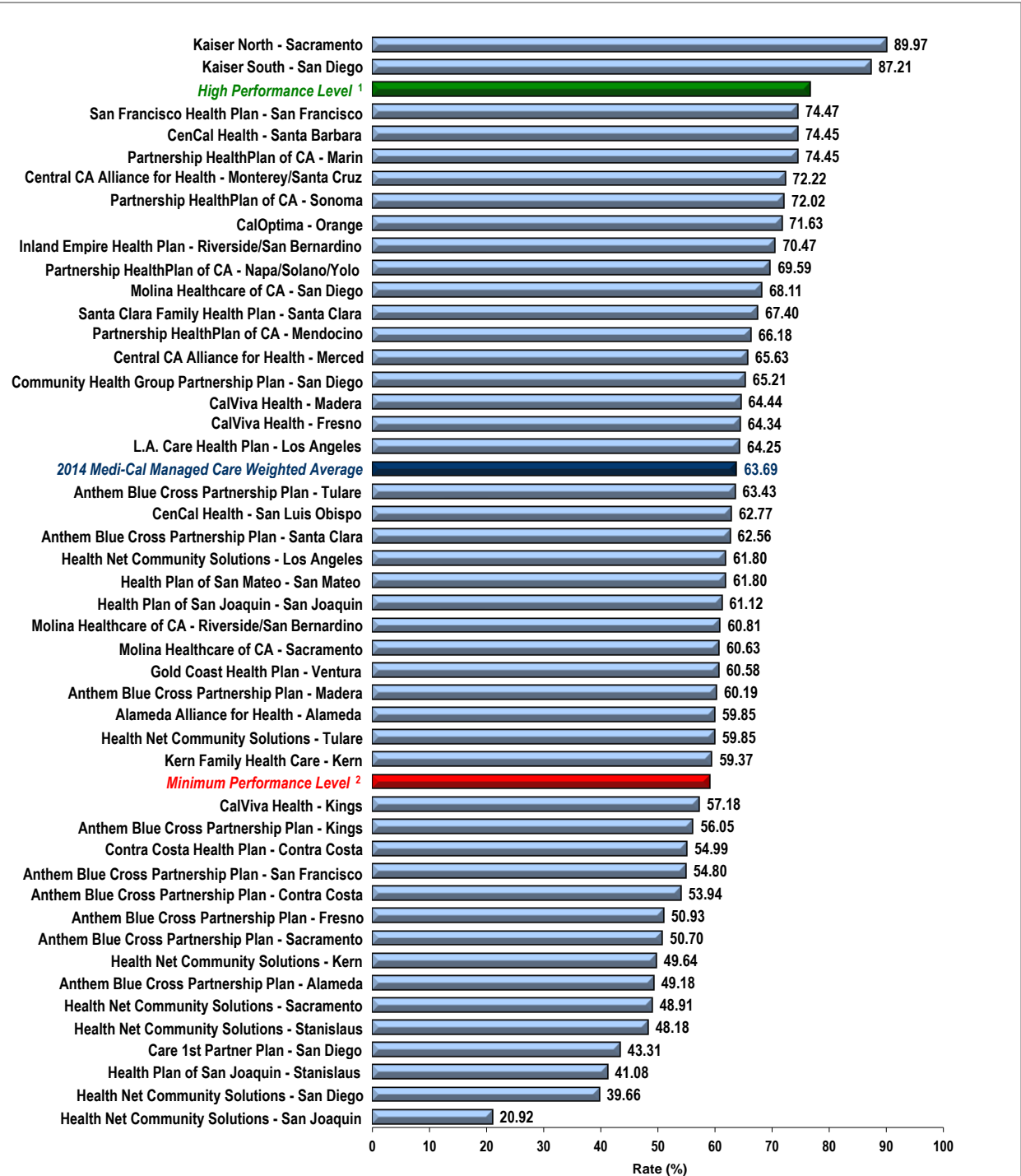
Healthy People 2020 goal: 93.00%

Note:

◆ The percentage displayed on this chart represents the Medi-Cal Weighted Average for 2014.



Medi-Cal Managed Care
 HEDIS 2014 Cervical Cancer Screening



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results

MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008. Due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014 and was not included as part of NCQA's public reporting set. Consequently, HSAG did not include or make comparisons to previous years' rates in this report, and DHCS did not hold the MCPs accountable to meet the national Medicaid 25th percentile (MPL) for 2014. The MCP rates displayed for this measure are baseline rates.

The 2014 Medi-Cal weighted average was lower than the national Medicaid and commercial averages and the Healthy People 2020 goal of 93.00 percent. The COHS model outperformed the TPM and GMC model.

High and Low Performers

The rates for Kaiser North—Sacramento County and Kaiser South—San Diego County were above the national Medicaid 90th percentile (HPL), and the rates for 15 MCP counties were below the MPL. While DHCS did not hold the MCPs accountable to meet the MPL in 2014, it is important that the MCPs with rates below the MPL implement quality improvement efforts to ensure their rates for this measure are above the MPL in 2015, the first year DHCS will hold MCPs to the MPL.

Best and Emerging Practices—Cervical Cancer Screening

In order to prevent cervical cancer, women must be screened; however, many health plans find that members are not compliant with being screened. The Community Preventive Services Task Force found that client reminders, providing videos or printed materials, and one-on-one education were the most effective interventions for increasing cervical cancer screening.³⁵

MHPA's Center for Best Practices provides information on efforts that have resulted in an increase in adherence to recommended care. Following are two examples of initiatives that may help MCPs improve cervical cancer screening rates.³⁶

OmniCare Health Plan

African-American women are more likely to be diagnosed with and die from cervical cancer than White women—primarily because of lack of screening and unequal access. To address this issue, OmniCare Health Plan in Michigan implemented multiple interventions to engage African-

³⁵ The Community Guide: Cancer Prevention and Control: Client-Oriented Interventions to Increase Breast, Cervical, and Colorectal Cancer Screening. Available at <http://www.thecommunityguide.org/cancer/screening/client-oriented/index.html>. Accessed on: July 17, 2014.

³⁶ Medicaid Health Plans of America: Centers for Best Practices. *Treatment Adherence: Best Practices Compendium*. Available at: <http://www.mhpa.org/upload/adherenceCompendiumWeb2.pdf>. Accessed on: August 7, 2014.

American women and educate them about the benefits of regular Pap screenings. Since breast cancer is the second most common cause of cancer death among African-American women, the health plan's interventions also included education about the benefits of regular mammogram screening. Interventions with focus on improving cervical cancer screening rates included:

- ◆ Sending targeted mailings and placing follow-up telephone calls to chronically noncompliant members.
- ◆ Implementing a direct messaging campaign (mail and telephone calls) identifying women who were missing both their mammogram and Pap screenings.
- ◆ Partnering with a physician's group/radiology facility and an OB/PCP site for scheduled appointments at each site on the same day.
 - Transportation was arranged and OmniCare Health Plan coordinated members being shuttled between the two locations.
- ◆ Providing PCPs with real-time electronic listings of noncompliant members that they can access from their offices 24 hour a day, 7 days a week.
- ◆ Providing an on-screen pop-up to health plan customer service department representatives to indicate when an incoming call is from a noncompliant member. The representative can then discuss needed screenings with the member.

As a result of the various interventions, OmniCare saw continuous improvement in the cervical cancer screening rate from 2008 to 2010.

Amerigroup

In order to support patients and help them gain access to needed services, Amerigroup implemented the TXT2Care intervention in its Maryland and Texas (Houston area) health plans. The health plans explored using two-way text messaging as a tool to improve utilization of preventive services. The program resulted in approximately 71 percent of members who responded "yes" to the text getting their care access needs met. Additionally, the program made the care management process more productive and efficient. While the health plan did not specifically report on how the TXT2Care intervention impacted cervical cancer screening rates, the positive results suggest that it could be an effective approach for improving adherence to cervical cancer screening.

Childhood Immunization Status—Combination 3

Measure Definition

The *Childhood Immunization Status—Combination 3* measure calculates the percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three Haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Importance

Disease prevention is the key to public health, and one of the most basic methods for the prevention of diseases is immunization. Immunizations are the safest and most effective tools for protecting children from various potentially serious childhood diseases. Vaccines are proven to help children stay healthy and avoid the harmful effects of diseases such as diphtheria, tetanus, hepatitis, polio, measles, mumps, and rubella. Vaccines also help stop the spread of an infectious disease to others in the community. While the rates of vaccine-preventable diseases are very low in the United States, the only eradicated disease is smallpox. All other viruses and bacteria that cause these infectious diseases still exist. In 2013, there were multiple measles outbreaks throughout the country, specifically among groups with low vaccine rates. If national vaccine rates drop, the spread of once preventable diseases may become commonplace and return to pre-vaccine levels.³⁷ Additionally, the National Committee for Quality Assurance (NCQA) estimates that 14 million cases of infectious diseases are prevented directly due to vaccines, and health care costs are reduced by \$9.9 billion in direct costs and \$33.4 billion in indirect costs.³⁸

Despite the established guidelines and documented benefits and risks associated with childhood immunization, a gap in coverage still exists. Previous evidence showed that the population at greatest risk for under-immunization was minority children from low-income families or children that live in inner-city or rural areas.³⁹ In 2013, more than 90 percent of kindergarten-aged children had all or the majority of recommended vaccinations. Currently, parents are refusing or delaying vaccinations due to concerns over a potential harmful side effect.⁴⁰ For these reasons, leading health care organizations and professionals widely agree that the need to focus on increasing childhood immunization rates in the United States still remains crucial.⁴¹

³⁷ Centers for Disease Control and Prevention. What Would Happen If We Stopped Vaccinations? Updated May 2014. Available at: <http://www.cdc.gov/vaccines/vac-gen/whatifstop.htm> Accessed on: June 10, 2014.

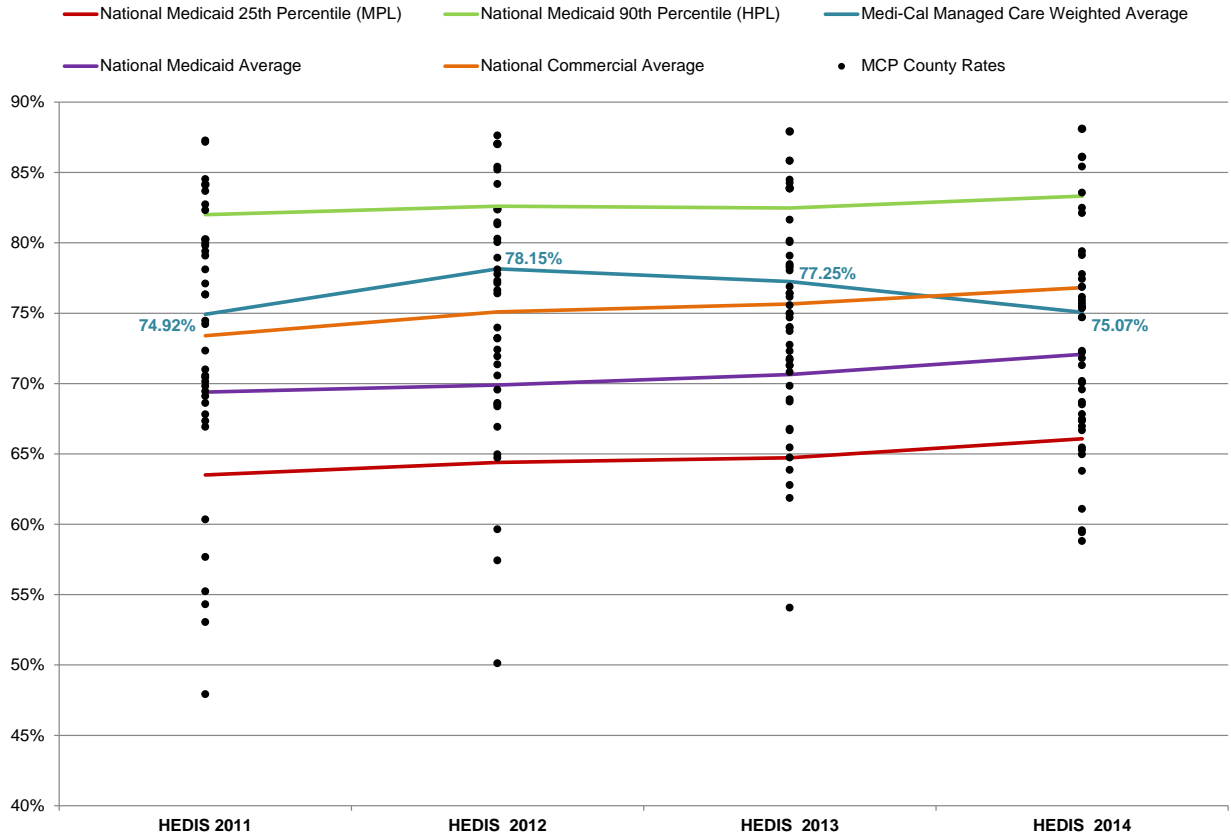
³⁸ National Committee for Quality Assurance. The State of Health Care Quality in 2013. Washington, D.C.: NCQA; 2009.

³⁹ American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine and Council on Community Pediatrics. "Increasing Immunization Coverage." *Pediatrics*. 2003; 112(4): 993–996.

⁴⁰ Institute of Medicine. January 2013. The Childhood Immunization Schedule and Safety: Stakeholder Concerns, Scientific Evidence, and Future Studies. Available at http://iom.edu/~media/Files/Report%20files/2013/Childhood-Immunization-Schedule/ChildhoodImmunizationScheduleandSafety_RB.pdf. Accessed on: June 10, 2014.

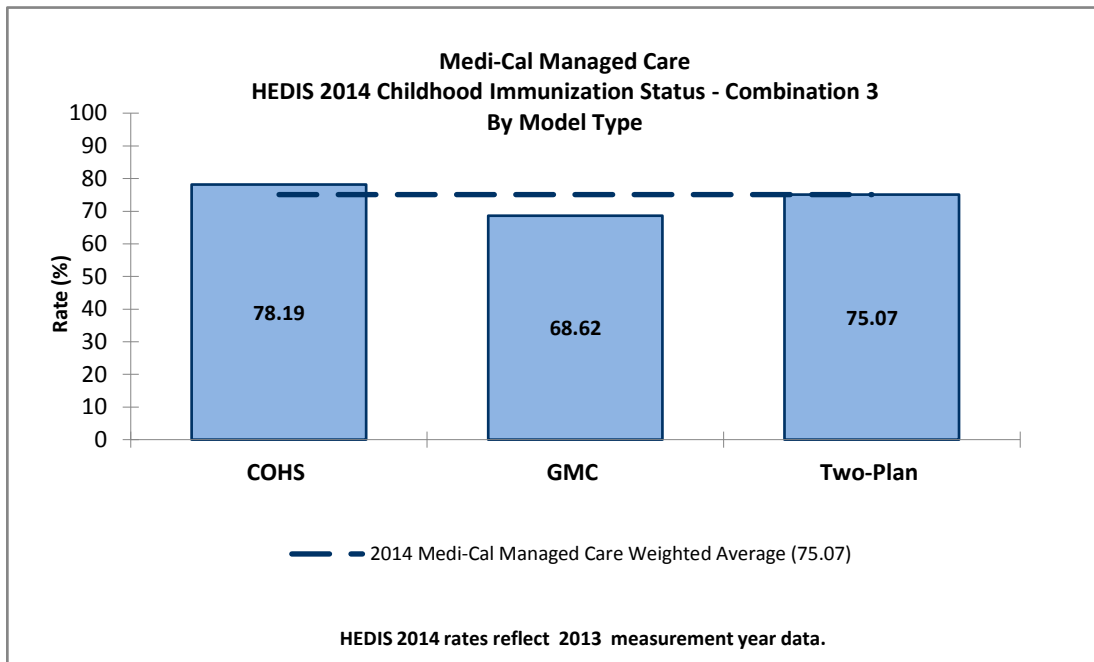
⁴¹ Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 11th ed. Washington, DC: Public Health Foundation; 2009. Available at: <http://www.cdc.gov/vaccines/pubs/pinkbook/index.html#chapters>. Accessed on: September 10, 2013.

Performance Results—Childhood Immunization Status—Combination 3

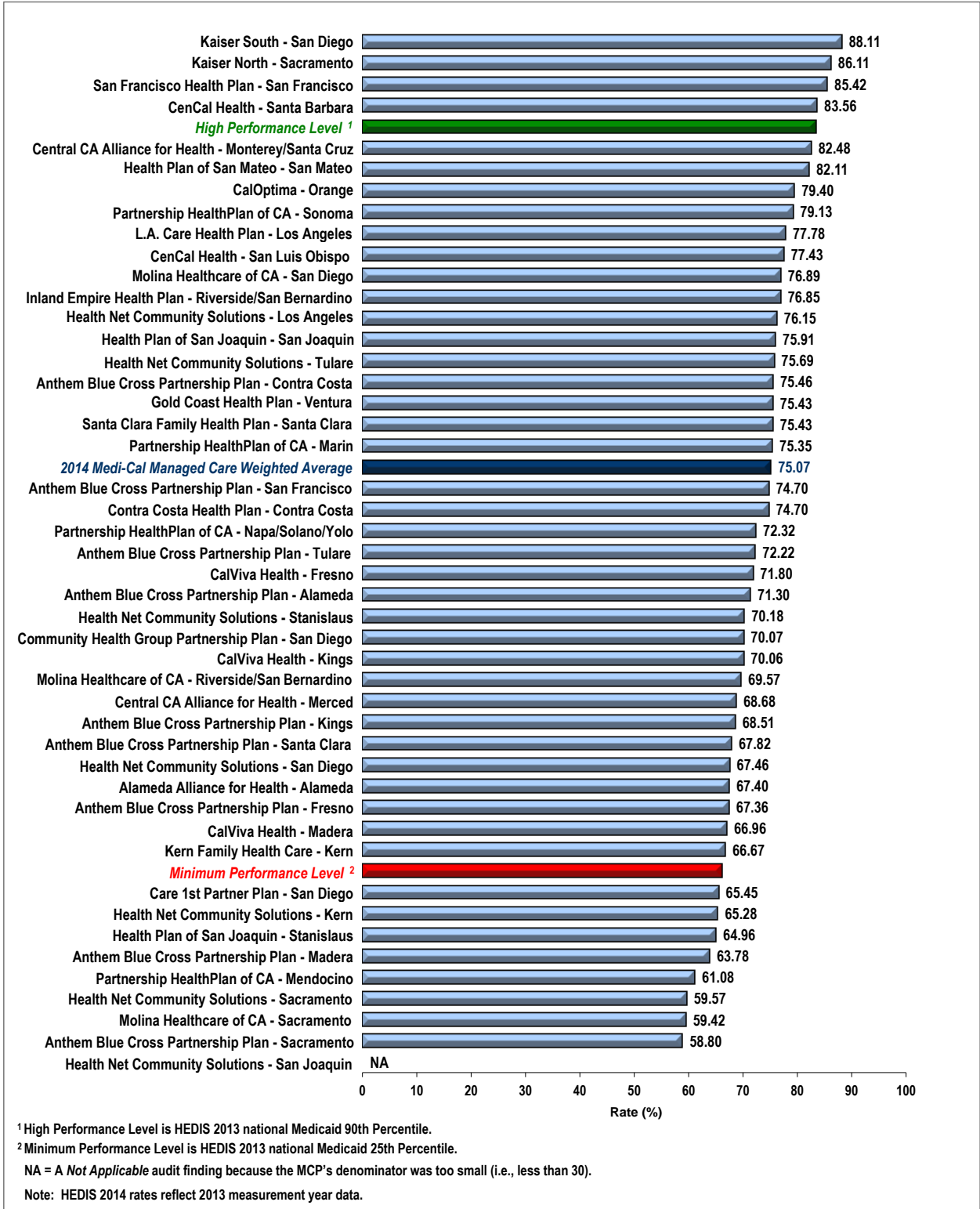


Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Childhood Immunization Status—Combination 3



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.
² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.
 NA = A Not Applicable audit finding because the MCP's denominator was too small (i.e., less than 30).
 Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results

For the fourth consecutive year, the MCMC weighted average for the *Childhood Immunization Status—Combination 3* measure was better than the national Medicaid 25th percentile (MPL) and national Medicaid average for this measure. The rate for this measure declined by more than 2 percentage points from 2013 to 2014, resulting in the rate moving from above the national commercial average to below the national commercial average. The rate remained below the national Medicaid 90th percentile (HPL) for the fourth consecutive year. Consistent with 2013, the COHS model outperformed the TPM and GMC model.

High and Low Performers

The rates for four MCP counties were above the HPL, compared to seven rates in 2013. Three of the MCP county rates were above the HPL for the fourth consecutive year:

- ◆ Cen Cal Health—Santa Barbara County
- ◆ Kaiser South—San Diego County
- ◆ San Francisco Health Plan—San Francisco County

The rate for Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino counties improved from 2013 to 2014. Although the improvement was not statistically significant, the rate moved from below the MPL in 2013 to above the MPL in 2014.

The rates for eight MCP counties were below the MPL in 2014 compared to four in 2013. (Note: The rate for Health Plan of San Joaquin—Stanislaus County was one of the eight rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL).

Health Net Community Solutions, Inc.—Kern County saw a decline in its rate from 2013 to 2014. Although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in 2013 to below the MPL in 2014.

The rates for the following six MCP counties declined significantly from 2013 to 2014:

- ◆ Alameda Alliance for Health—Alameda County
- ◆ Anthem Blue Cross Partnership Plan—Madera County and Santa Clara County
- ◆ Care1st Partner Plan—San Diego County
- ◆ Contra Costa Health Plan—Contra Costa County
- ◆ Health Net Community Solutions, Inc.—Sacramento County

The decline in the rates for Anthem Blue Cross Partnership Plan—Madera County and Care1st Partner Plan—San Diego County resulted in the rates moving from above the MPL in 2013 to below the MPL in 2014. (Note: 2013 was the first year Anthem Blue Cross Partnership Plan reported a rate for Madera County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

The rates for Anthem Blue Cross Partnership Plan—Sacramento County and Molina Healthcare of California Partner Plan, Inc.—Sacramento County were below the MPL for the fourth consecutive year.

Best and Emerging Practices—Childhood Immunization Status—Combination 3

Vaccines are a vital part of stopping the spread of diseases. The following types of interventions and strategies recommended by the Community Preventive Services Task Force have been shown to increase the vaccination rates among a wide range of the population:⁴²

- ◆ Home visits
- ◆ Reducing client out-of-pocket costs
- ◆ Vaccination programs in schools and child care centers
- ◆ Vaccination programs in the Women, Infants, and Children (WIC) Program
- ◆ Member incentives
- ◆ Member reminder systems
- ◆ Community-based interventions
- ◆ Vaccination requirements for child care and schools
- ◆ Immunization information systems
- ◆ Provider assessment and feedback
- ◆ Provider reminders
- ◆ Standing orders

⁴² The Community Guide: Increasing Appropriate Vaccination. Available at: <http://www.thecommunityguide.org/vaccines/index.html>. Accessed on: July 17, 2014.

Children and Adolescents' Access to Primary Care Practitioners

Measure Definition

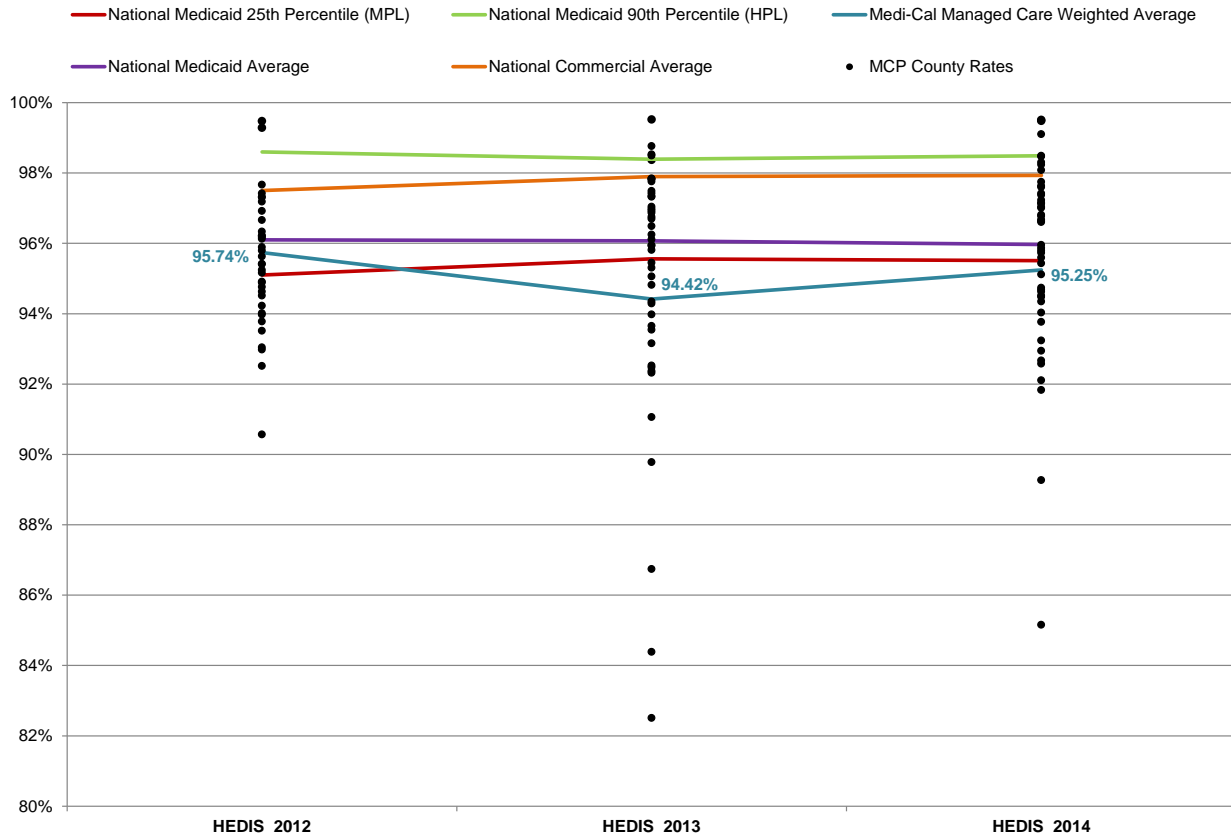
This measure is used to assess the percentage of members 12 months through 24 months and 25 months through 6 years of age who had a visit with a primary care practitioner during the measurement year and members 7 years through 11 years and 12 years through 19 years of age who had a visit with a primary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

Importance

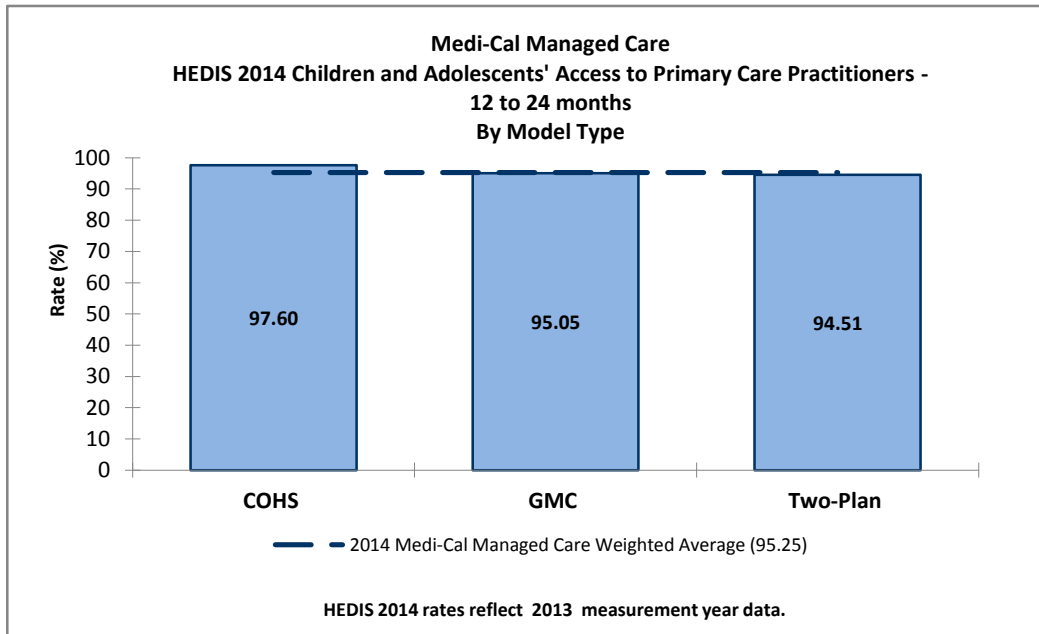
A child's health and wellness is connected to his or her ability to access primary care. In 2011, NCQA indicated that the medical needs of 2.5 million children were not met and 2 million children were considered in "fair to poor" health. Evidence has shown that primary care services can significantly reduce the amount of non-urgent emergency room (ER) visits for children 18 years of age and younger. By strengthening primary care services, health outcomes improve and health care costs are reduced.⁴³

⁴³ National Committee for Quality Assurance. The State of Health Care Quality in 2013. Washington, D.C.: NCQA; 2009.

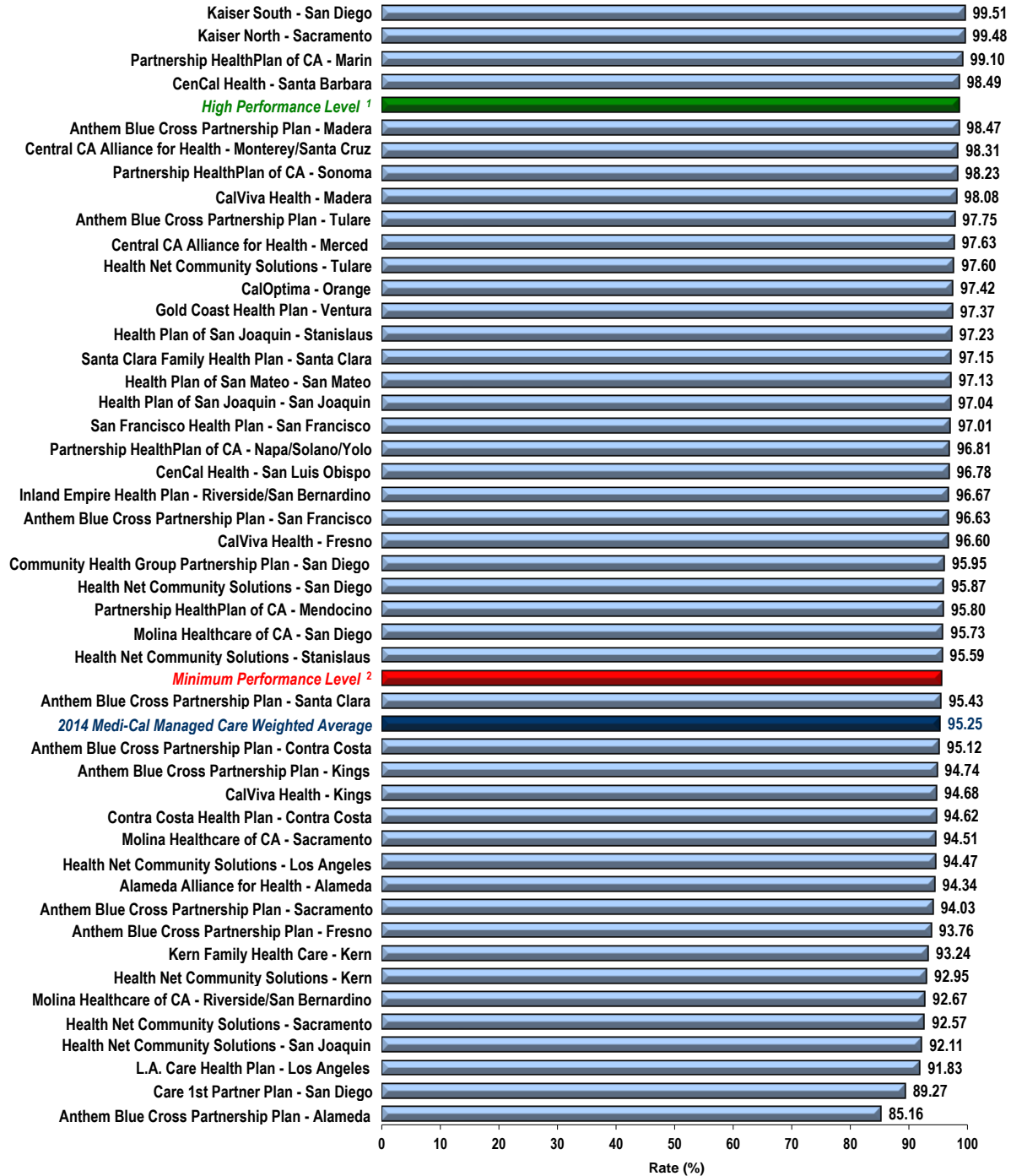
Performance Results—Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months



Note:
 ♦ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
 ♦ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
 ♦ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months

The MCMC weighted average for *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measure improved by less than 1 percentage point from 2013 to 2014 and was below the national Medicaid 25th percentile (MPL) for the second consecutive year. Additionally, the rate was below the national Medicaid and commercial averages for the third consecutive year. The COHS model outperformed the TPM and GMC model, which is consistent with the previous two years.

High and Low Performers

Although MPLs and HPLs were established for the *Children and Adolescents' Access to Primary Care Practitioners* measures, DHCS elected not to hold the MCPs to the MPLs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures in 2013 or 2014 to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact. Since the measures were first reported in 2012, DHCS did not hold the MCPs accountable to meet the MPLs for the measures in 2012. Although DHCS did not hold the MCPs accountable to meet the MPLs for the measures, HSAG provides an assessment of the rates compared to the MPL and national Medicaid 90th Percentile (HPL).

The rates for four MCP counties were above the HPL, and the rate for Kaiser South—San Diego County was above the HPL for the third consecutive year. The following MCP county rates improved from below the MPL in 2013 to above the MPL in 2014:

- ◆ Anthem Blue Cross Partnership Plan—Tulare County
- ◆ CenCal Health—San Luis Obispo County
- ◆ Gold Coast Health Plan—Ventura County (Note: 2013 was the first year Gold Coast Health Plan reported a rate for Ventura County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).
- ◆ Health Net Community Solutions, Inc.—San Diego County
- ◆ Partnership HealthPlan of California—Mendocino County

The rates for 18 MCP counties were below the MPL. (Note: The rate for Health Net Community Solutions, Inc.—San Joaquin County was one of the 18 rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL).

Although not statistically significant, the rates for the following MCP counties declined from 2013 to 2014, resulting in the rates moving from above the MPL in 2013 to below the MPL in 2014:

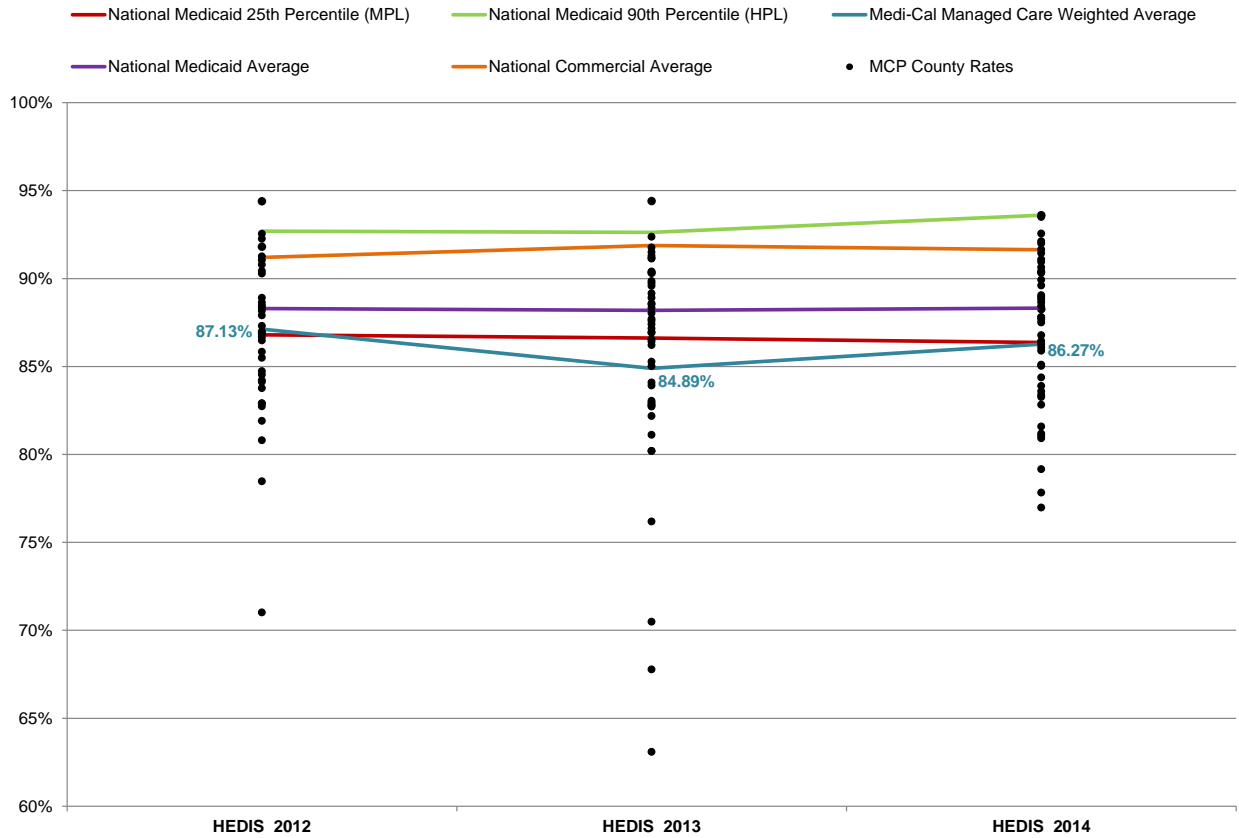
- ◆ Anthem Blue Cross Partnership Plan—Contra Costa County
- ◆ Anthem Blue Cross Partnership Plan—Santa Clara County
- ◆ CalViva Health—Kings County (Note: 2013 was the first year CalViva Health reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

The rates for nine MCP counties improved significantly from 2013 to 2014, and the rates for the following three MCP counties declined significantly from 2013 to 2014:

- ◆ CalViva Health—Fresno County
- ◆ Care1st Partner Plan—San Diego County
- ◆ Community Health Group Partnership Plan—San Diego County

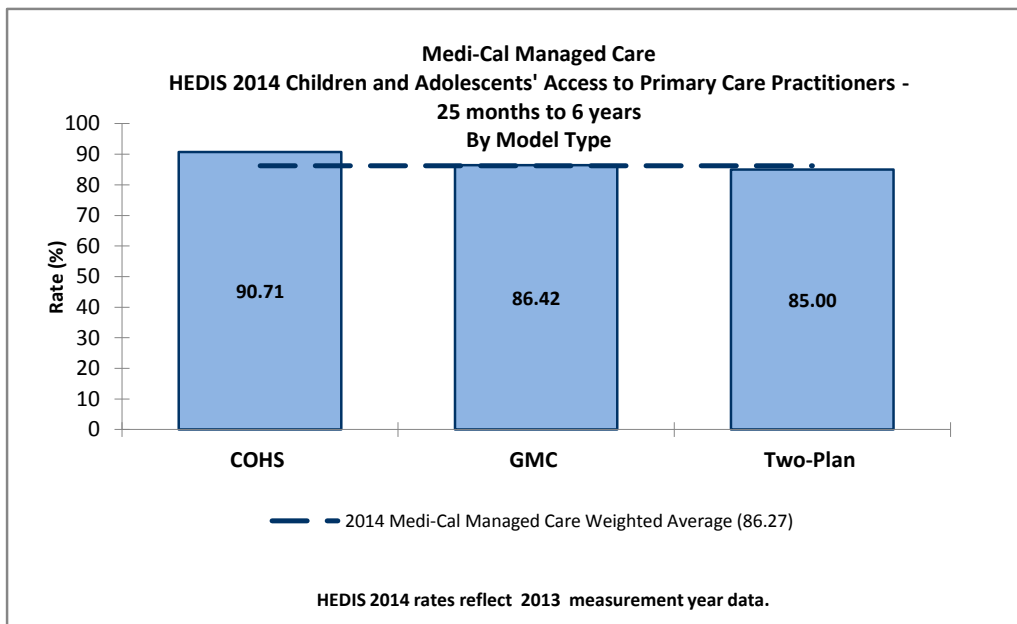
The rates for eight MCP counties were below the MPL for the third consecutive year. (Note: The rates for two of these MCP counties, Alameda Alliance for Health—Alameda County and Health Net Community Solutions, Inc.—Kern County, improved significantly from 2013 to 2014).

Performance Results—Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years



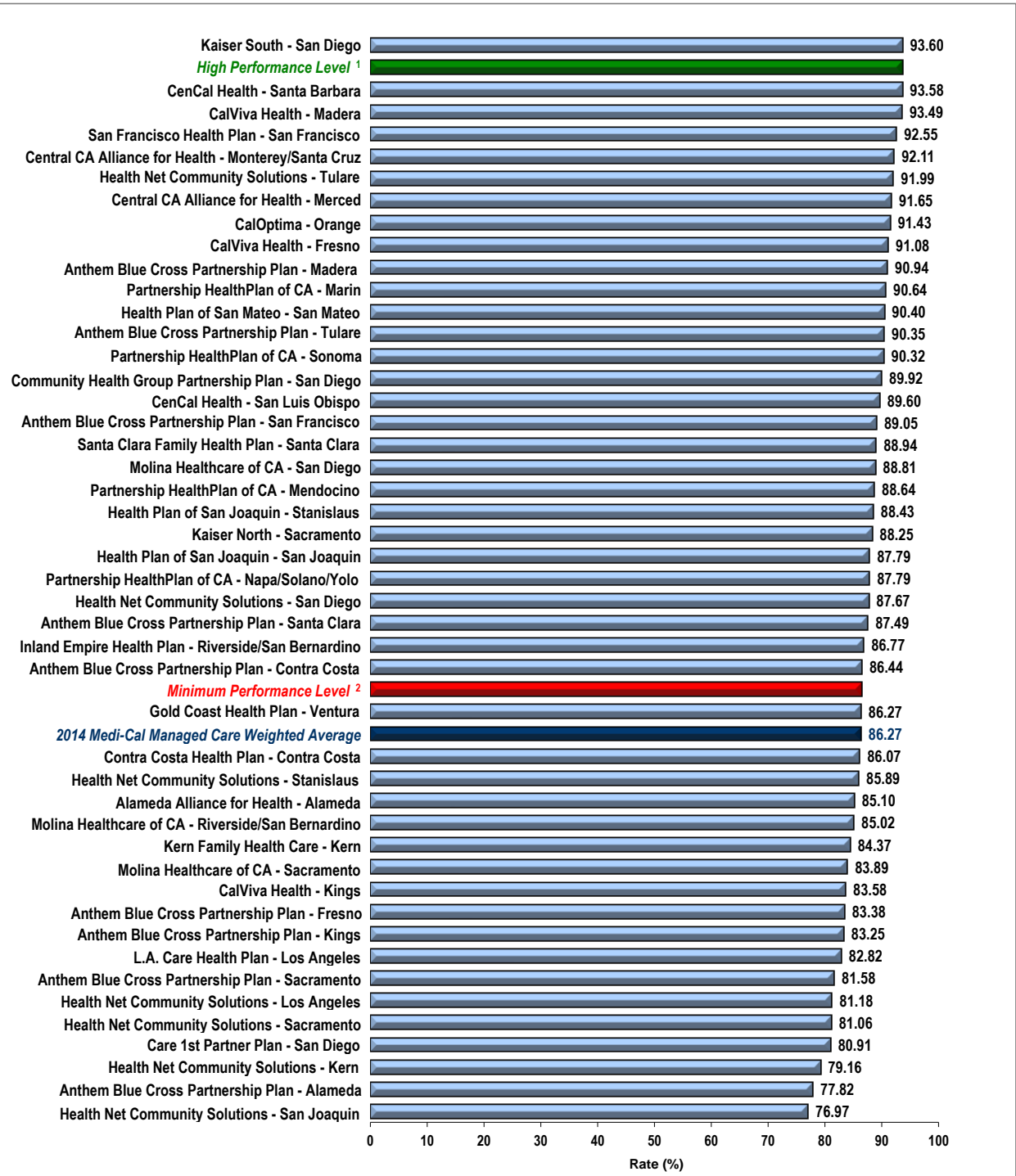
Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care

HEDIS 2014 Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years

The MCMC weighted average for *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* measure improved by less than 2 percentage points from 2013 to 2014 and was below the national Medicaid 25th percentile (MPL) for the second consecutive year. Additionally, the rate was below the national Medicaid and commercial averages for the third consecutive year. The COHS model outperformed the TPM and GMC model, which is consistent with the previous two years.

High and Low Performers

Although MPLs and HPLs were established for the *Children and Adolescents' Access to Primary Care Practitioners* measures, DHCS elected not to hold the MCPs to the MPLs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures in 2013 or 2014 to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact. Since the measures were first reported in 2012, DHCS did not hold the MCPs accountable to meet the MPLs for the measures in 2012. Although DHCS did not hold the MCPs accountable to meet the MPLs for the measures, HSAG provides an assessment of the rates compared to the national MPL and national Medicaid 90th Percentile (HPL).

Kaiser South—San Diego County's rate was above the HPL for the third consecutive year, and 18 MCP county rates were below the MPL. (Note: The rate for Health Plan of San Joaquin—Stanislaus County was one of the 18 rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL).

The rates for 22 MCP counties improved significantly from 2013 to 2014. The improvement for the following MCP counties resulted in the rates moving from below the MPL in 2013 to above the MPL in 2014:

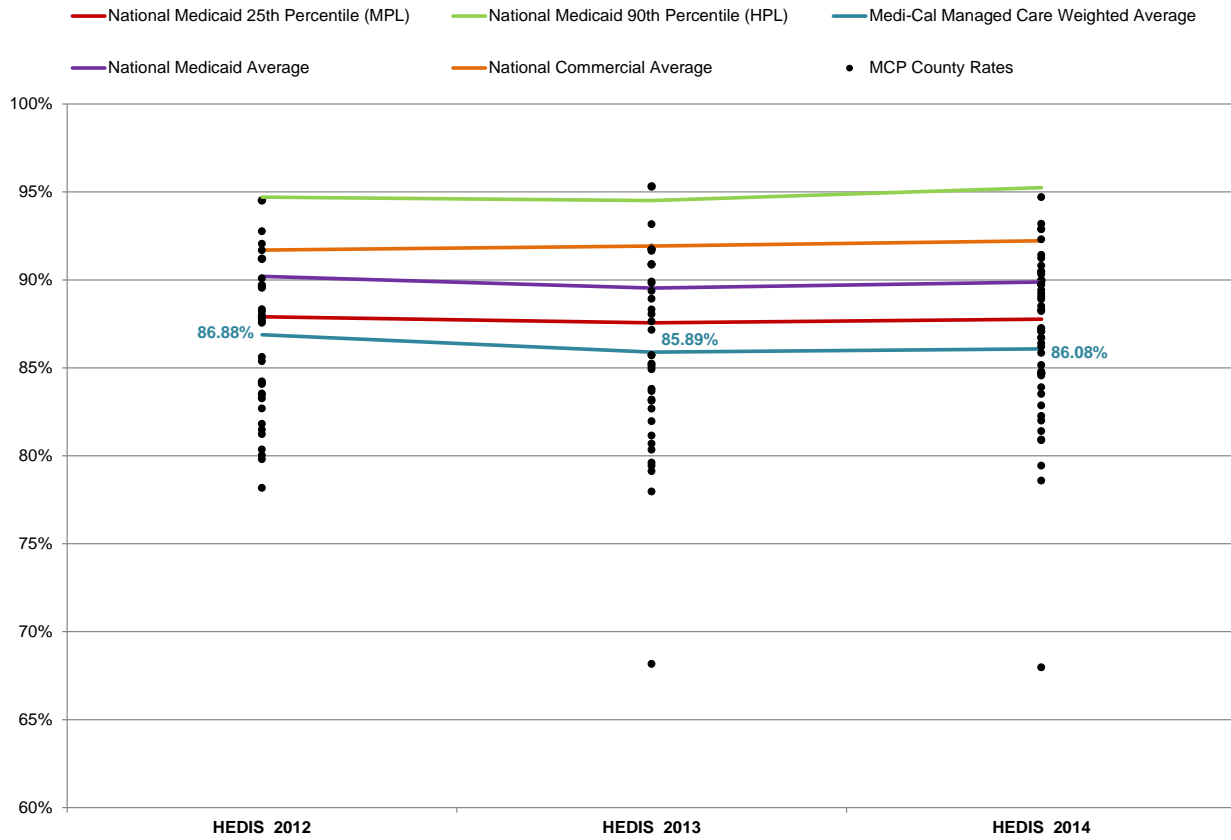
- ◆ Anthem Blue Cross Partnership Plan—Tulare County
- ◆ CenCal Health—San Luis Obispo County
- ◆ Health Net Community Solutions, Inc.—San Diego County
- ◆ Partnership HealthPlan of California—Napa/Solano/Yolo counties

Additionally, the rate for Anthem—Contra Costa County improved from 2013 to 2014, and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL to above the MPL.

The rates for five MCP counties declined significantly from 2013 to 2014. The significant decline in the rates for CalViva Health—Kings County and Health Net Community solutions, Inc.—Stanislaus County resulted in the rates moving from above the MPL in 2013 to below the MPL in 2014. (Note: 2013 was the first year CalViva Health reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

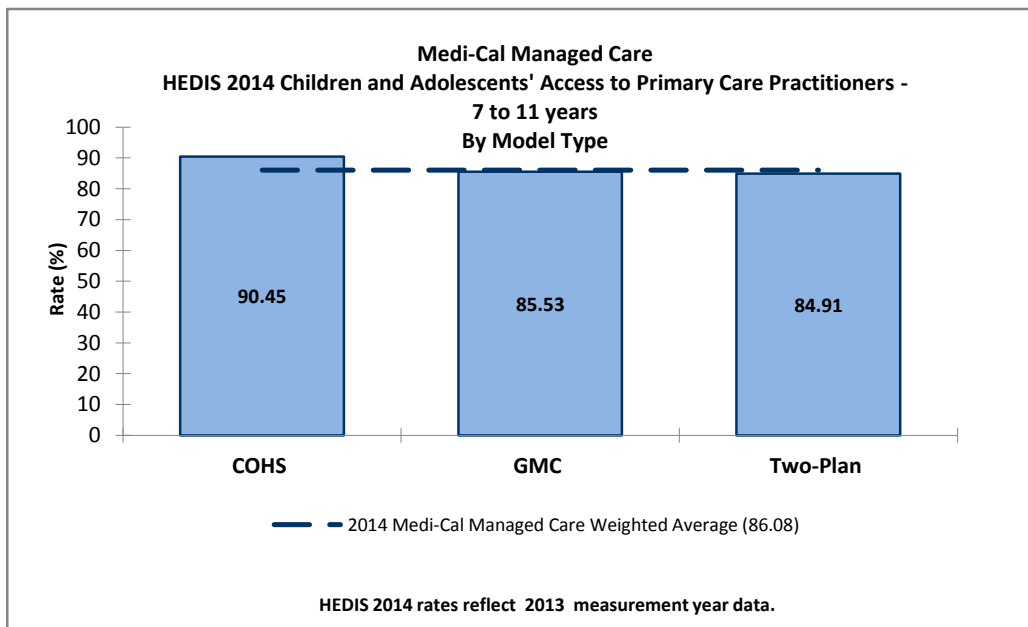
The rates for 10 MCP counties were below the MPL for the third consecutive year. (Note: the rates for seven of these MCP counties improved significantly from 2013 to 2014).

Performance Results—Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years

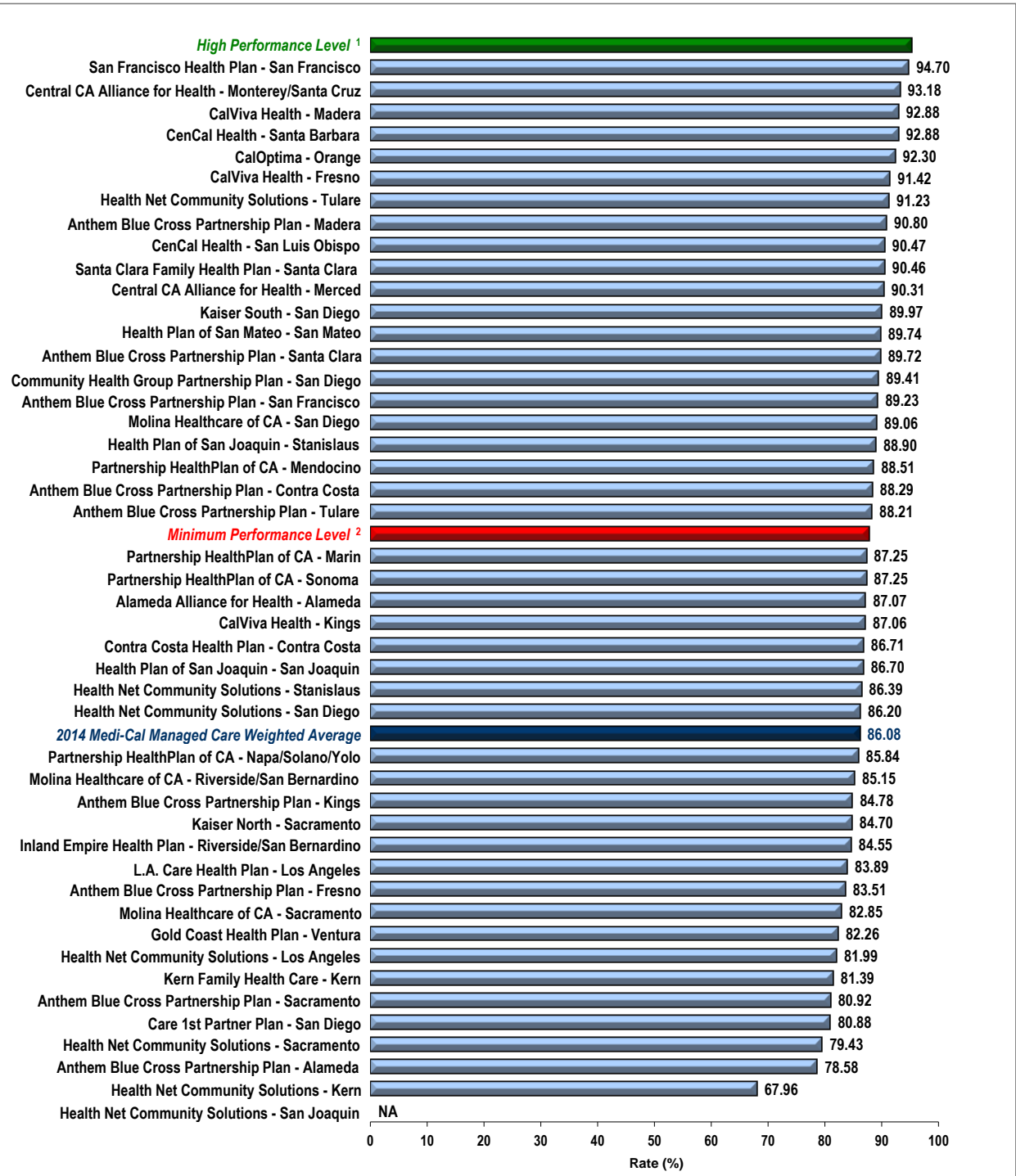


Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.
² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.
 NA = A *Not Applicable* audit finding because the MCP's denominator was too small (i.e., less than 30).
 Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years

The MCMC weighted average for *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure was below the national Medicaid 25th percentile (MPL) and national Medicaid and commercial averages for the third consecutive year. The COHS model outperformed the TPM and GMC model, which is consistent with the previous two years.

High and Low Performers

Although MPLs and HPLs were established for the *Children and Adolescents' Access to Primary Care Practitioners* measures, DHCS elected not to hold the MCPs to the MPLs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures in 2013 or 2014 to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact. Since the measures were first reported in 2012, DHCS did not hold the MCPs accountable to meet the MPLs for the measures in 2012. Although DHCS did not hold the MCPs accountable to meet the MPLs for the measures, HSAG provides an assessment of the rates compared to the MPL and national Medicaid 90th Percentile (HPL).

No MCP county rates were above the HPL in 2014, and the rates for 24 MCP counties were below the MPL. Health Net Community Solutions, Inc.—San Joaquin County had an audit result of “NA” for this measure, meaning that although the MCP complied with all applicable specifications, it had a denominator less than 30 for the measure, resulting in the “NA” audit result.

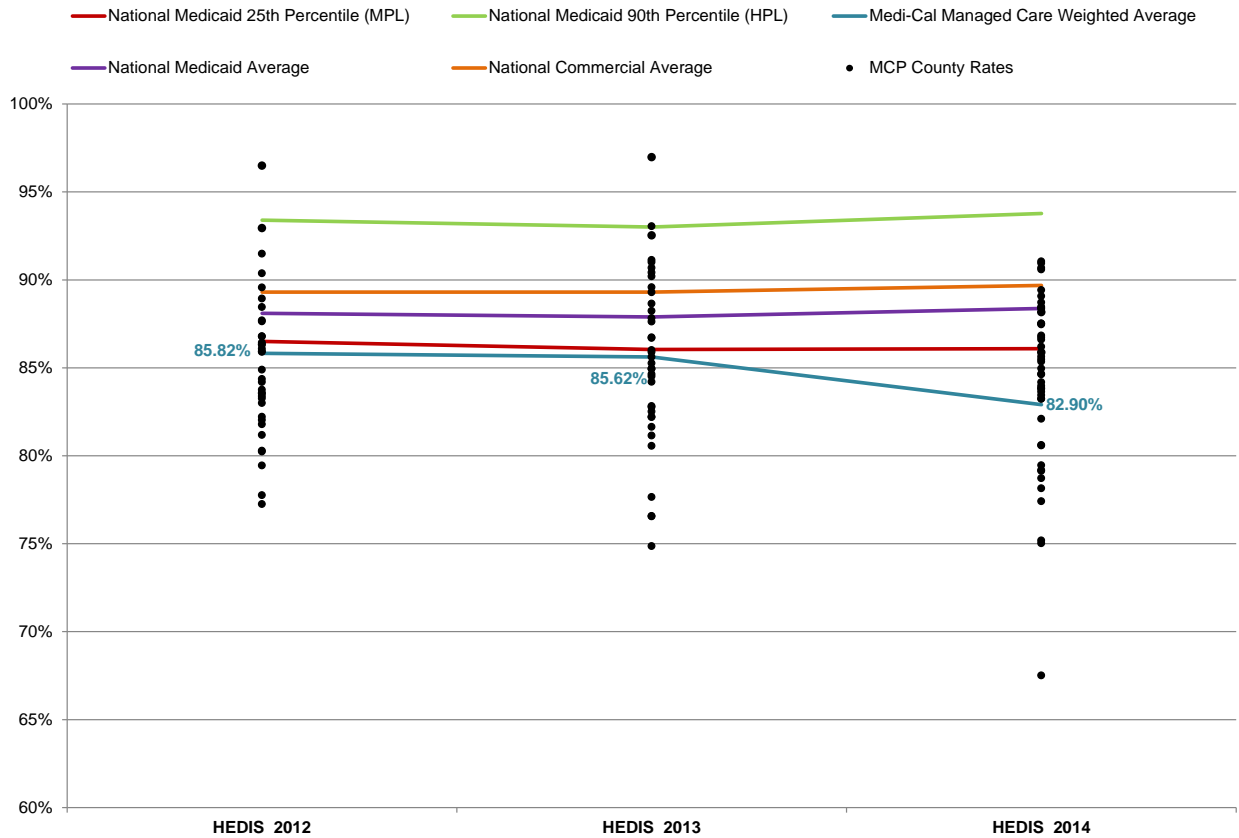
The rates for 18 MCP counties improved significantly from 2013 to 2014. The significant improvement for Anthem Blue Cross Partnership Plan—Contra Costa County and Tulare County resulted in the rates moving from below the MPL in 2013 to above the MPL in 2014.

The rate for Kaiser North—Sacramento County declined significantly from 2013 to 2014, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014. Three other MCP counties had rates that declined significantly from 2013 to 2014:

- ◆ Health Net Community Solutions, Inc.—Los Angeles County
- ◆ Kaiser South—San Diego County
- ◆ L.A. Care Health Plan—Los Angeles County

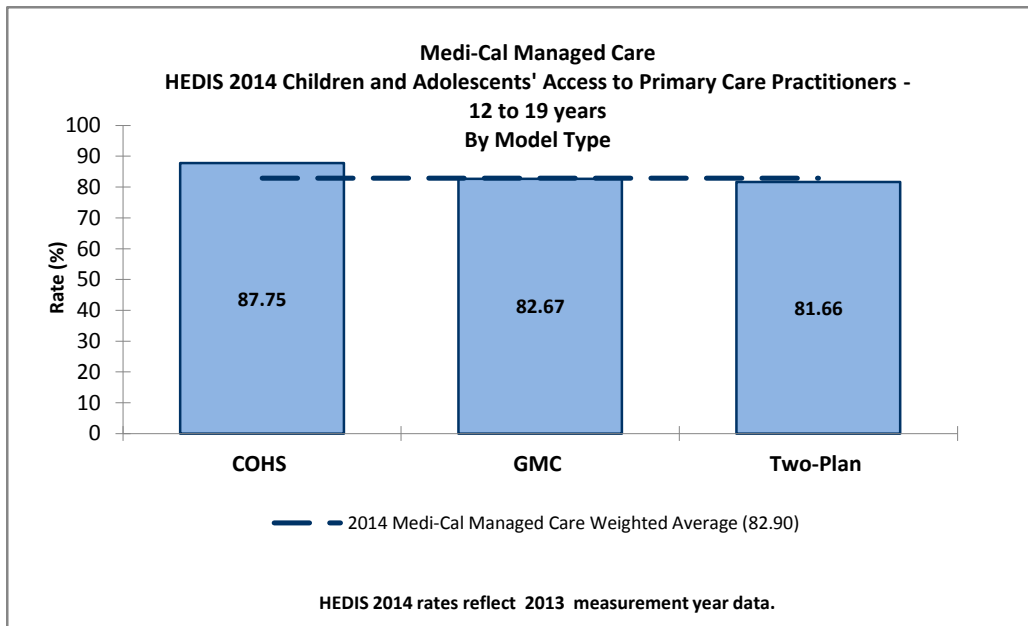
The rates for 15 MCP counties were below the MPL for the third consecutive year. (Note: The rates for eight of these MCP counties improved significantly from 2013 to 2014).

Performance Results—Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years

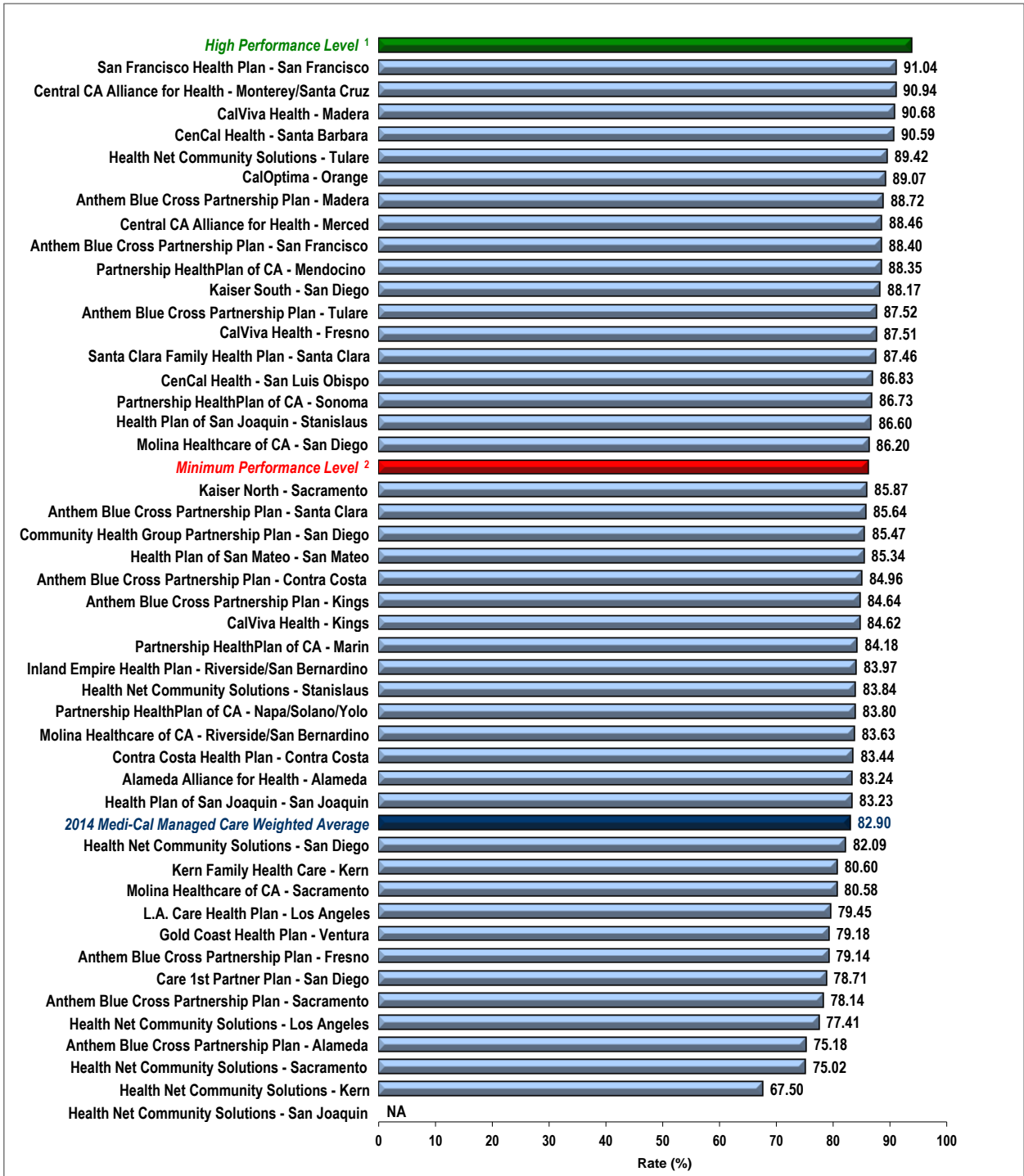


Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small (i.e., less than 30).

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years

The MCMC weighted average for *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure declined by almost 3 percentage points from 2013 to 2014. For the third consecutive year, the rate was below the national Medicaid 25th percentile (MPL) and national Medicaid and commercial averages for this measure. The COHS model outperformed the TPM and GMC model, which is consistent with the previous two years.

High and Low Performers

Although MPLs and HPLs were established for the *Children and Adolescents' Access to Primary Care Practitioners* measures, DHCS elected not to hold the MCPs to the MPLs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures in 2013 or 2014 to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact. Since the measures were first reported in 2012, DHCS did not hold the MCPs accountable to meet the MPLs for the measures in 2012. Although DHCS did not hold the MCPs accountable to meet the MPLs for the measures, HSAG provides an assessment of the rates compared to the MPL and national Medicaid 90th Percentile (HPL).

No MCP county rates were above the HPL in 2014, and the rates for 27 MCP counties were below the MPL. Health Net Community Solutions, Inc.—San Joaquin County had an audit result of “NA” for this measure, meaning that although the MCP complied with all applicable specifications, it had a denominator less than 30 for the measure, resulting in the “NA” audit result.

The rate for Molina Healthcare of California Partner Plan, Inc.—San Diego County improved from 2013 to 2014, and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014. The rates for four MCP counties improved significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—Fresno County and Tulare County
- ◆ CenCal Health—Santa Barbara County
- ◆ Contra Costa Health Plan—Contra Costa County
 - Although the rate for this MCP county improved significantly from 2013 to 2014, the rate remained below the MPL for the third consecutive year.

The improvement for Anthem Blue Cross Partnership Plan—Tulare County resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014. Although the rate for Contra Costa Health Plan improved significantly, the rate remained below the MPL for the third consecutive year.

The rates for 23 MCP counties declined significantly from 2013 to 2014, and the rates for 13 of these MCP counties were below the MPL for the third consecutive year. Additionally, four MCP counties with rates that did not decline significantly were below the MPL for the third consecutive year. Finally, the rates for four MCP counties with rates that declined significantly moved from above the MPL in 2013 to below the MPL in 2014:

- ◆ Anthem Blue Cross Partnership Plan—Santa Clara County
- ◆ Community Health Group Partnership Plan—San Diego County
- ◆ Inland Empire Health Plan—Riverside/San Bernardino counties
- ◆ Kaiser North—Sacramento County

Best and Emerging Practices—Children and Adolescents' Access to Primary Care Practitioners

Having access to primary care practitioners can help ensure the health and wellness of children and adolescents. The following types of interventions can result in improved access, resulting in better health for children and adolescents.

United Healthcare Community & State

United Healthcare Community & State's Baby Blocks program engages expectant and new mothers with a mobile-optimized game board that reminds them of upcoming prenatal, postpartum, and well-child appointments through 15 months of age. The online and mobile engagement tool aligns with the demographic and ethnographic profiles of its members, and pregnant members are enrolled through direct mail, outreach calls, and provider marketing. The health plan continuously communicates with enrolled members through e-mail or text reminders about appointments and tips for healthy living. The pilot phase showed promising results, and at the time of the report, the program had the potential to reach nearly 50,000 pregnant women.⁴⁴

Amerigroup Maryland

Amerigroup Maryland developed the Adolescent Well Care Outreach Initiative in 2010. The health plan assembled a multidisciplinary team to develop interventions and monitor utilization of wellness services for adolescent members aged 12 to 20 years old. The multidisciplinary team addresses barriers to adolescent members receiving routine well care visits and provides incentives to high-volume providers to bring members into care. Amerigroup also partners with high-volume PCP offices to host wellness clinics during various school breaks and conducts outbound calls to members to coordinate appointments and to assist with transportation. Members attending a

⁴⁴ Medicaid Health Plans of America: Centers for Best Practices. *2012–2013 Best Practices Compendium*. Available at: https://www.mhpa.org/_upload/2012Compendium.pdf. Accessed on: August 7, 2014.

wellness visit are provided incentives such as gift cards, school supplies, and a chance to win an iPod. In 2011, the health plan began remote appointment scheduling with participating providers using the MyHealthDirect software program. MyHealthDirect also gives members a choice of how they wish to receive appointment reminders—via text or e-mail. Amerigroup Maryland reported a 10.9 percentage point increase in adolescent well-care visits from 2010 to 2011.⁴⁵

Department of Health & Human Services

States and other stakeholders are implementing a variety of approaches to increase adolescent well-care visit rates and awareness of preventive services.⁴⁶ The Department of Health & Human Services recommends the following six strategies help to promote adolescent use of preventive services:

- ◆ Adopting current Bright Futures guidelines for adolescents.
- ◆ Incentivizing providers, adolescents, and adolescents' parents to encourage preventive care.
- ◆ Encouraging teen-centered care.
- ◆ Leveraging missed opportunities to increase adolescent well-care visits (i.e., using episodic, acute care, and sport-required visits to increase preventive care, immunizations, and health education).
- ◆ Using social media to increase well-care visits.
- ◆ Developing partnerships with key community stakeholders to increase accessibility (i.e., making appointments available in accessible community locations or schools, providing evening and weekend appointments).

⁴⁵ Medicaid Health Plans of America: Centers for Best Practices. *2012–2013 Best Practices Compendium*. Available at: <https://www.mhpa.org/upload/2012Compendium.pdf>. Accessed on: August 7, 2014.

⁴⁶ Department of Health & Human Services. *Paving the Road to Good Health. Strategies for Increasing Medicaid Adolescent Well-Care Visits*. Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Paving-the-Road-to-Good-Health.pdf>. Accessed on August 10, 2014.

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

Measure Definition

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

Importance

High blood pressure (i.e., hypertension) is one of the leading complications of diabetes.⁴⁷ Two-thirds of diabetics have hypertension. Members with diabetes are at an increased risk for developing hypertension due to the effect diabetes has on a person's arteries, which can increase the risk of heart attack and stroke.^{48,49} A person who has a combination of diabetes and hypertension is four times more likely to develop heart disease than someone who does not have either condition.^{50,51} Furthermore, people with diabetes are two-to-four times more likely to have a stroke than non-diabetics. Other complications from high blood pressure include:

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

⁴⁷ American Diabetes Association. *High Blood Pressure (Hypertension)*. Available at: <http://www.diabetes.org/living-with-diabetes/complications/high-blood-pressure-hypertension.html>. Accessed on: September 11, 2013.

⁴⁸ WebMD. *Diabetes and High Blood Pressure*. Available at: <http://www.webmd.com/hypertension-high-blood-pressure/guide/high-blood-pressure>. Reviewed on: May 2012. Accessed on: September 11, 2013.

⁴⁹ National Diabetes Information Clearinghouse. *National Diabetes Statistics, 2011*. Available at: http://diabetes.niddk.nih.gov/dm/pubs/statistics/DM_Statistics_508.pdf. Accessed on: September 4, 2014.

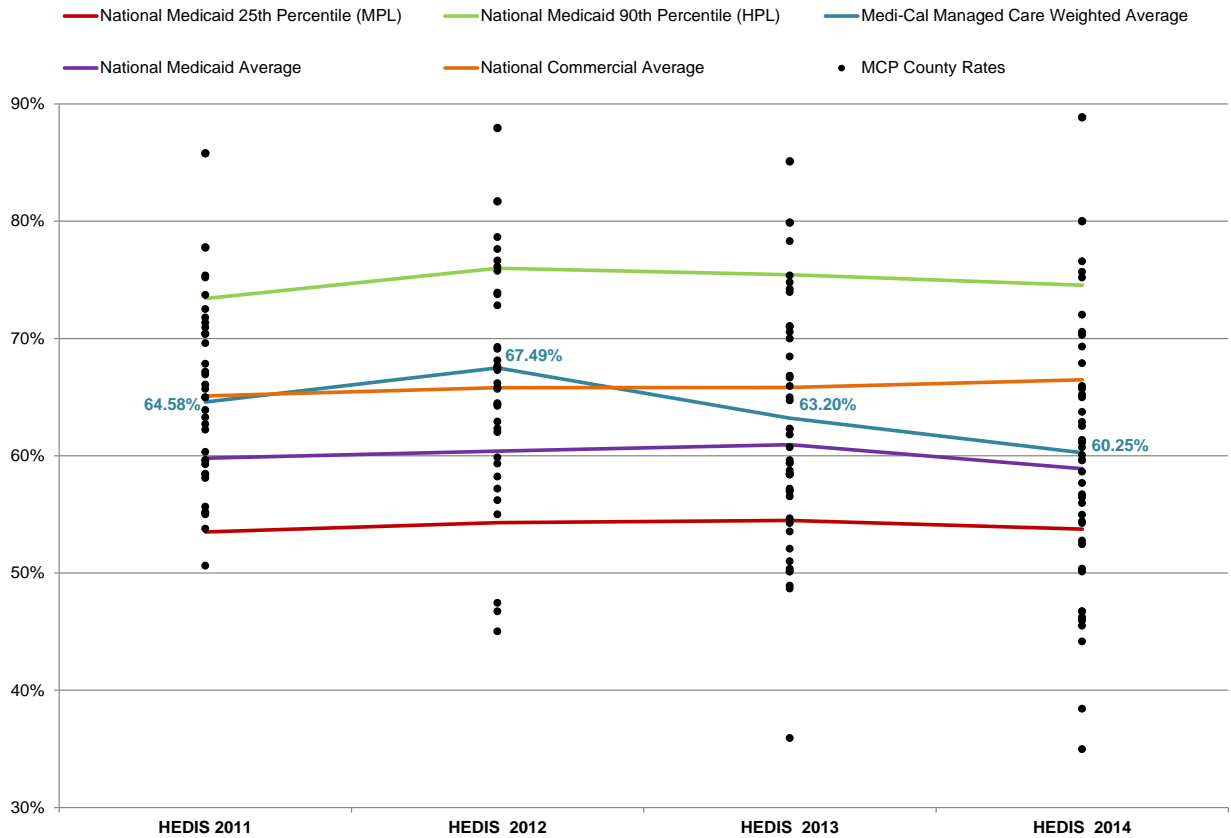
⁵⁰ Ibid.

⁵¹ American Diabetes Association. *High Blood Pressure (Hypertension)*. Available at: <http://www.diabetes.org/living-with-diabetes/complications/high-blood-pressure-hypertension.html>. Accessed on: September 11, 2013.

By controlling blood pressure, the occurrence of these complications is lowered. Blood pressure control in diabetics reduces the risk of heart disease and stroke by 33 and 50 percent, respectively. Additionally, blood pressure control reduces the risk of microvascular complications (e.g., eye, kidney, and nerve diseases) by approximately 33 percent. In early treatment of diabetic kidney disease, the decline in kidney function decreases by 30 to 70 percent when blood pressure is controlled. For every 10 mm Hg reduction in systolic blood pressure, the risk for any complication related to diabetes is decreased by 12 percent.⁵²

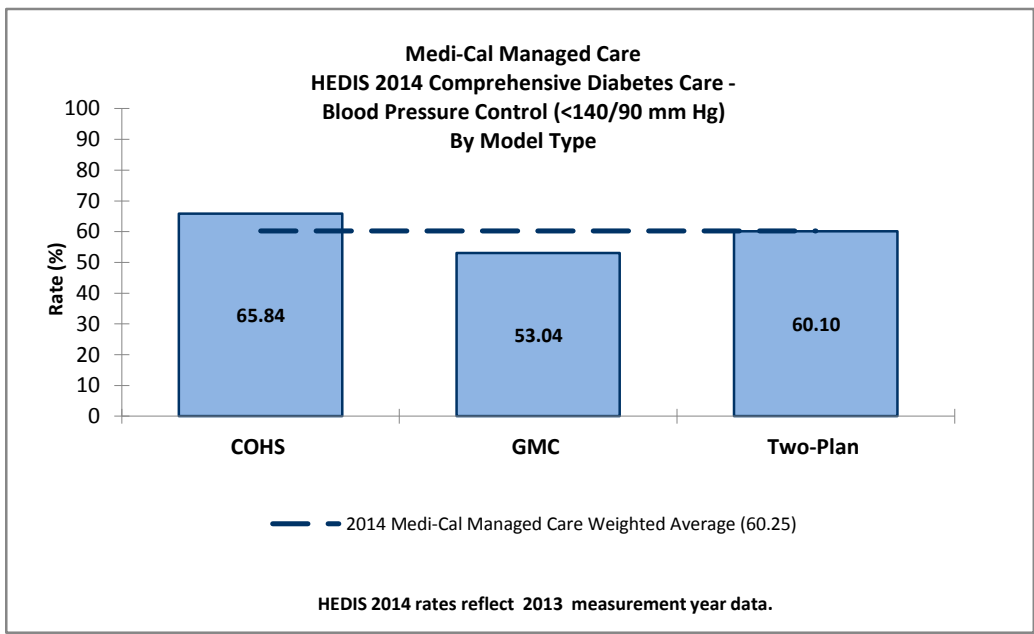
⁵² National Diabetes Information Clearinghouse. National Diabetes Statistics, 2011. Available at: http://diabetes.niddk.nih.gov/dm/pubs/statistics/DM_Statistics_508.pdf. Accessed on: September 4, 2014.

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

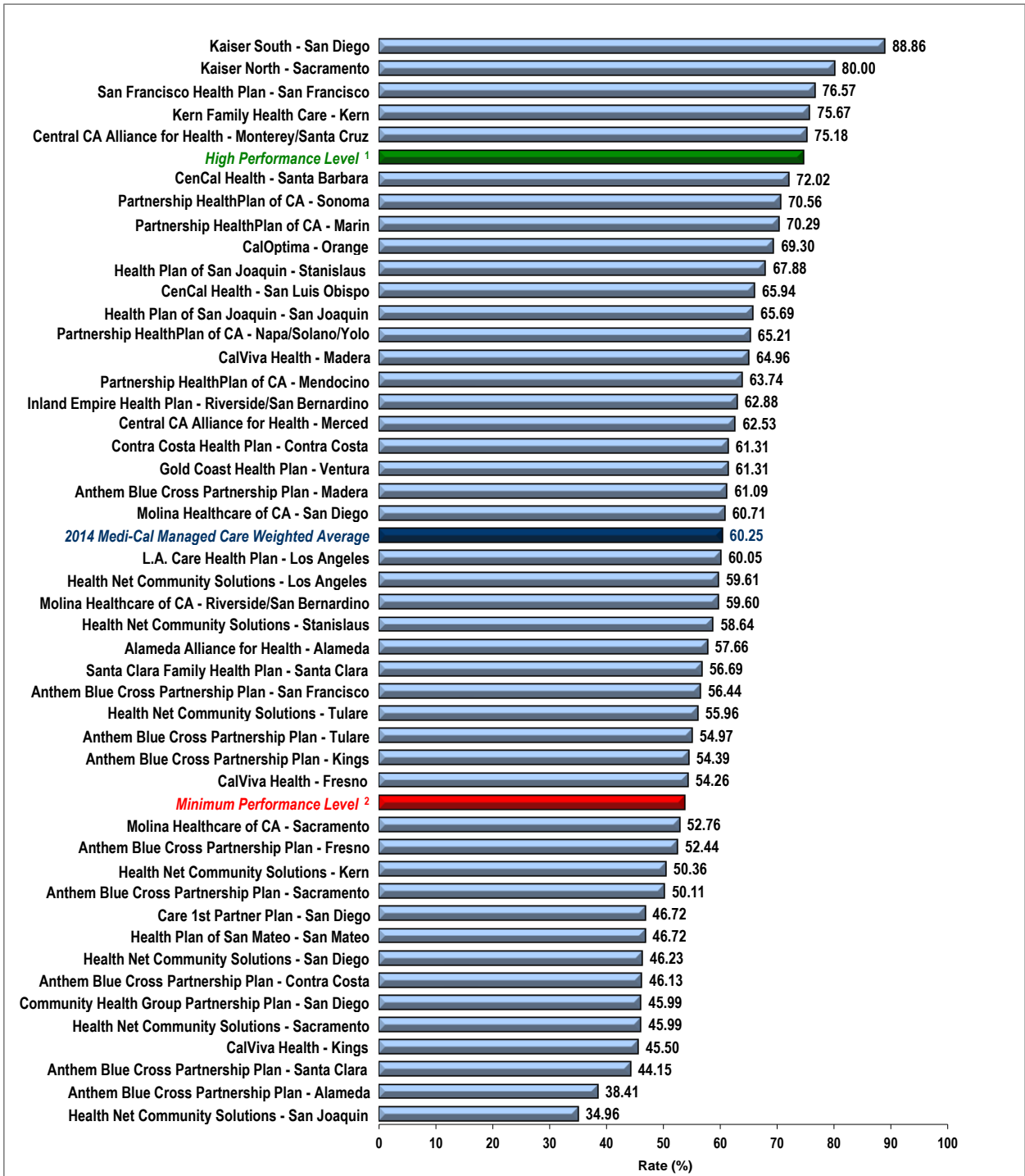


Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
HEDIS 2014 Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

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

The MCMC weighted average for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure declined by just under 3 percentage points from 2013 to 2014. For four consecutive years, the MCMC weighted average has exceeded the Healthy People 2020 goal, the national Medicaid 25th percentile (MPL), and the national Medicaid average. The rate has been below the national commercial average for two consecutive years.

The COHS model outperformed the TPM and GMC model for the fourth consecutive year.

High and Low Performers

For the fourth consecutive year, the rates for Kaiser North—Sacramento County and Kaiser South—San Diego County were above the national Medicaid 90th percentile (HPL). Additionally, the rate for Kaiser South—San Diego County improved significantly from 2013 to 2014. The rates for the following MCP counties also were above the HPL in 2014:

- ◆ Central California Alliance for Health—Monterey/Santa Cruz counties
- ◆ Kern Family Health Care—Kern County
- ◆ San Francisco Health Plan—San Francisco County

In addition to Kaiser South—San Diego County, the rates for the following MCP counties improved significantly from 2013 to 2014:

- ◆ Health Net Community Solutions, Inc.—Los Angeles County
- ◆ Partnership HealthPlan of California—Marin County and Mendocino County

The improvement in the rate for Health Net Community Solutions, Inc.—Los Angeles County resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014. Additionally, three other MCP counties had rates that improved from below the MPL in 2013 to above the MPL in 2014, although the improvement in their rates was not statistically significant.

The rates for 14 MCP counties were below the MPL in 2014, and eight MCP county rates declined significantly from 2013 to 2014:

- ◆ The rate for Anthem Blue Cross Partnership Plan—Alameda County was below the MPL for the fourth consecutive year.
- ◆ The rate for Anthem Blue Cross Partnership Plan—Contra Costa County was below the MPL for the third consecutive year.

- ◆ The statistically significant decline for five rates resulted in the rates moving from above the MPL in 2013 to below the MPL in 2014.
- ◆ Although the decline in the rates for Molina Healthcare of California Partner Plan, Inc.—Sacramento County and Anthem Blue Cross Partnership Plan—Fresno County were not statistically significant, the decline resulted in the rates moving from above the MPL in 2013 to below the MPL in 2014. (Note: Since Anthem Blue Cross Partnership Plan did not report rates for Fresno County in 2012, DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).
- ◆ The rate for Health Net Community Solutions, Inc.—San Joaquin was one of the 14 rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL.

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 received a retinal or dilated eye exam during the measurement year or a negative retinal or dilated eye exam in the year prior to the measurement year.

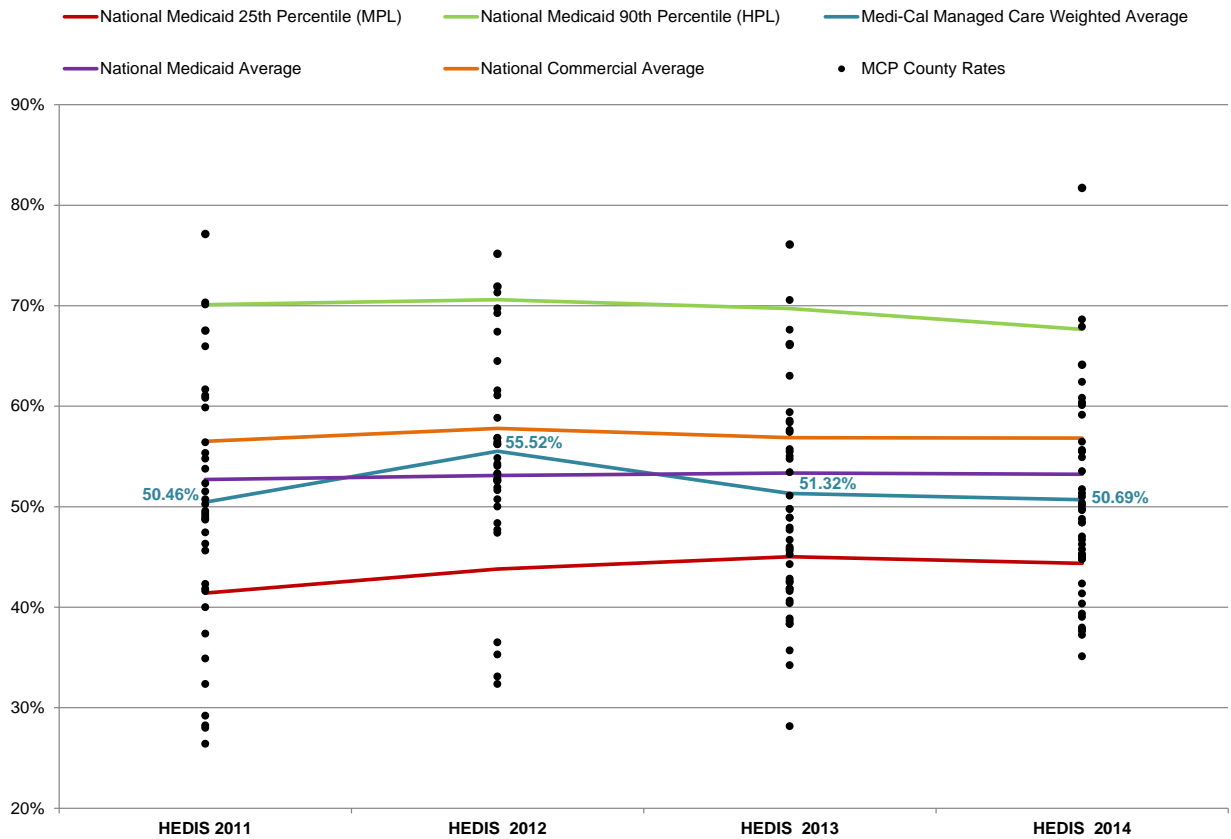
Importance

High blood sugar levels increase diabetics' risk of eye complications.⁵³ The three most common eye complications in diabetics are retinopathy, cataracts, and glaucoma.⁵⁴ Diabetics have an increased chance of 60 percent of obtaining cataracts over non-diabetics.⁵⁵ Furthermore, diabetics are more likely to develop a rare form of glaucoma called neovascular glaucoma than those without diabetes.⁵⁶

Detecting and treating diabetics with an eye disease can reduce the development of severe vision loss by approximately 50 to 60 percent. While most eye complications are minor, diabetics are at an increased risk of blindness.⁵⁷ Diabetes is the leading cause of blindness for adults between 20 and 74 years of age. Between 2005 and 2008, diabetic retinopathy affected 4.2 million diabetics and caused severe vision loss in 655,000 of those diabetics.⁵⁸

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- ⁵³ National Diabetes Information Clearinghouse. *National Diabetes Statistics, 2011*. Available at: http://diabetes.niddk.nih.gov/dm/pubs/statistics/DM_Statistics_508.pdf. Accessed on: September 4, 2014.
- ⁵⁴ WebMD. *Eye Problems and Diabetes*. Available at: <http://diabetes.webmd.com/eye-problems>. Accessed June 12, 2014.
- ⁵⁵ American Diabetes Association. *Eye Complications*. Available at: <http://www.diabetes.org/living-with-diabetes/complications/eye-complications>. Accessed on: September 11, 2013.
- ⁵⁶ WebMD. *Eye Problems and Diabetes*. Available at: <http://diabetes.webmd.com/eye-problems>. Accessed on: June 12, 2014.
- ⁵⁷ 2011 National Diabetes Fact Sheet. *Diagnosed and undiagnosed diabetes in the United States, all ages, 2010*. Available at: <http://www.cdc.gov/diabetes/pubs/estimates11.htm>. Accessed on: September 11, 2013.
- ⁵⁸ National Diabetes Information Clearinghouse. *National Diabetes Statistics, 2011*. Available at: http://diabetes.niddk.nih.gov/dm/pubs/statistics/DM_Statistics_508.pdf. Accessed on: September 4, 2014.

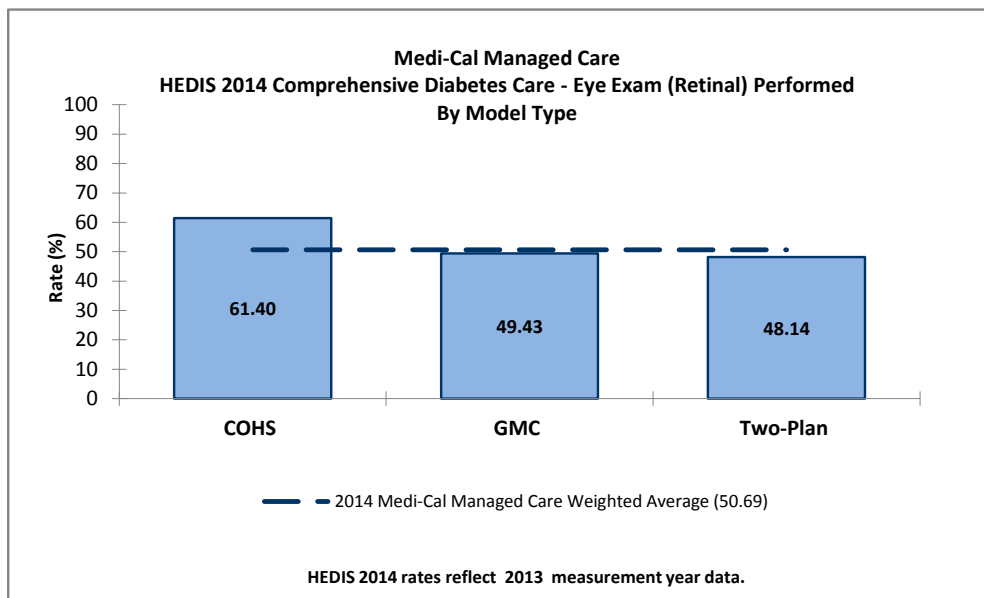
Performance Results—Comprehensive Diabetes Care—Eye Exam (Retinal) Performed



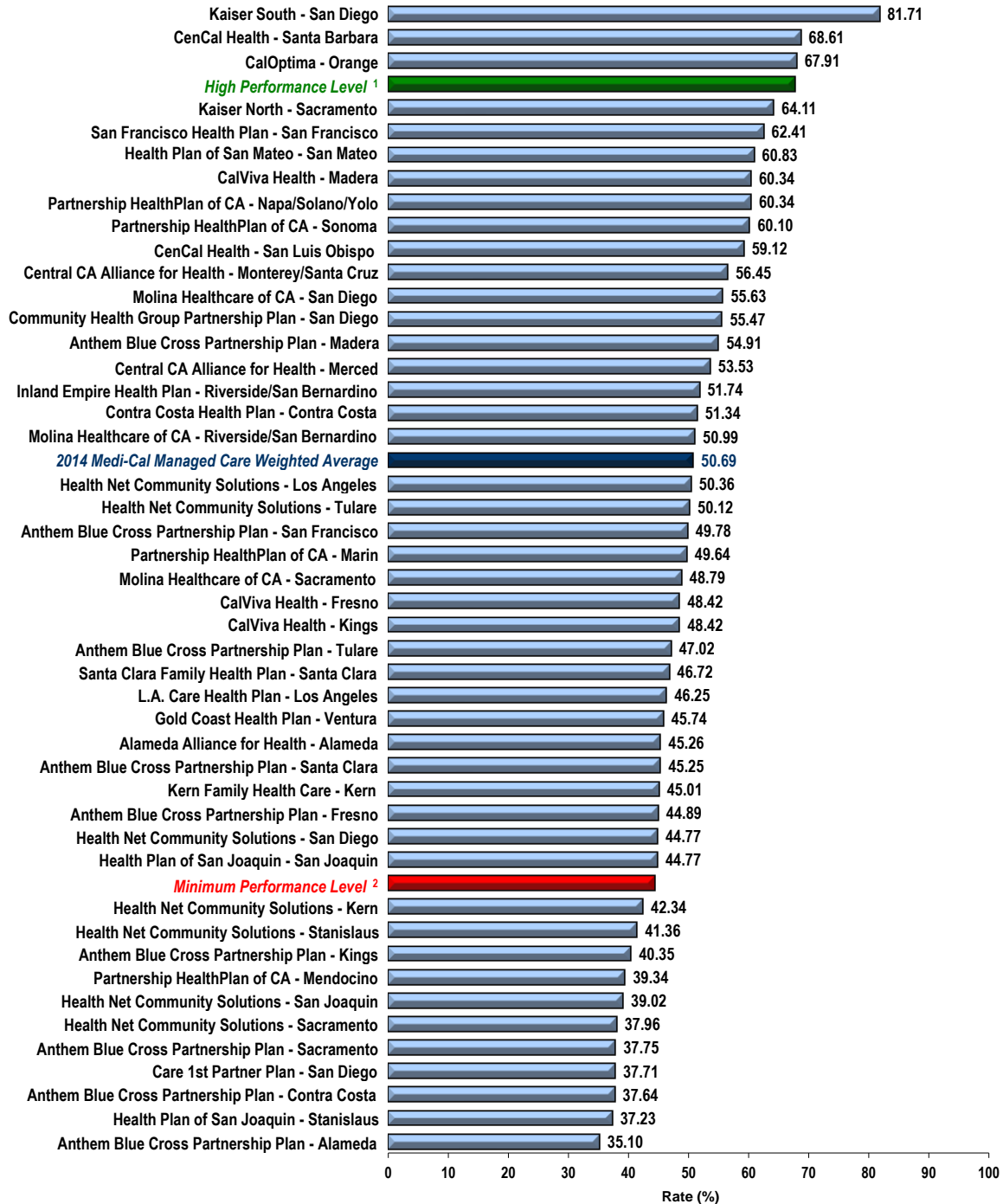
Healthy People 2020 Goal: 58.70%

Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
HEDIS 2014 Comprehensive Diabetes Care—Eye Exam (Retinal) Performed



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

The MCMC weighted average for the *Comprehensive Diabetes Care—Eye Exam (Retinal)* measure was above the national Medicaid 25th percentile (MPL) for the fourth consecutive year. The rate has been below the national commercial average and Healthy People 2020 goal for four consecutive years and below the national Medicaid average for two consecutive years. The COHS model outperformed the TPM and GMC model for the fourth consecutive year.

High and Low Performers

For the fourth consecutive year, the rates for Kaiser South—San Diego County and CenCal Health—Santa Barbara County were above the national Medicaid 90th percentile (HPL). Additionally, the rate for Kaiser South—San Diego County improved significantly from 2013 to 2014. The rate for CalOptima—Orange County also was above the HPL in 2014.

The rates for five MCP counties with non-statistically significant improvement improved from below the MPL in 2013 to above the MPL in 2014:

- ◆ Anthem Blue Cross Partnership Plan—Fresno County
- ◆ CalViva Health—Kings County (Note: 2013 was the first year CalViva Health reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).
- ◆ Gold Coast Health Plan—Ventura County (Note: 2013 was the first year Gold Coast Health Plan reported a rate for Ventura County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).
- ◆ Partnership HealthPlan of California—Marin County
- ◆ Santa Clara Family Health Plan—Santa Clara County

In addition to the rate for Kaiser South—San Diego County improving significantly from 2013 to 2014, the rates for the following MCP counties improved significantly:

- ◆ Anthem Blue Cross Partnership Plan—Sacramento County and Tulare County
- ◆ Health Net Community Solutions, Inc.—Tulare County
- ◆ Partnership HealthPlan of California—Napa/Sonoma/Yolo counties

The improvement for Anthem Blue Cross Partnership Plan—Tulare County and Health Net Community Solutions, Inc.—Tulare County resulted in the rates for these MCP counties improving from below the MPL in 2013 to above the MPL in 2014.

The rate for Inland Empire Health Plan—Riverside/San Bernardino counties declined significantly from 2013 to 2014. The rates for 11 MCP counties were below the MPL in 2014, and the rates for three of these MCP counties—Anthem Blue Cross Partnership Plan—Alameda County, Contra Costa County, and Sacramento County—were below the MPL for the fourth consecutive year.

Note:

- ◆ Although the rate for Anthem Blue Cross Partnership Plan—Sacramento County was below the MPL for the fourth consecutive year, the rate improved significantly from 2013 to 2014.
- ◆ The rate for Health Net Community Solutions, Inc.—San Joaquin County and Health Plan of San Joaquin—Stanislaus County were two of the 11 rates below the MPL in 2014; however, 2014 was the first year the MCPs reported rates for this measure for these counties and DHCS therefore did not hold the MCPs accountable to meet the MPL.

Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)

Measure Definition

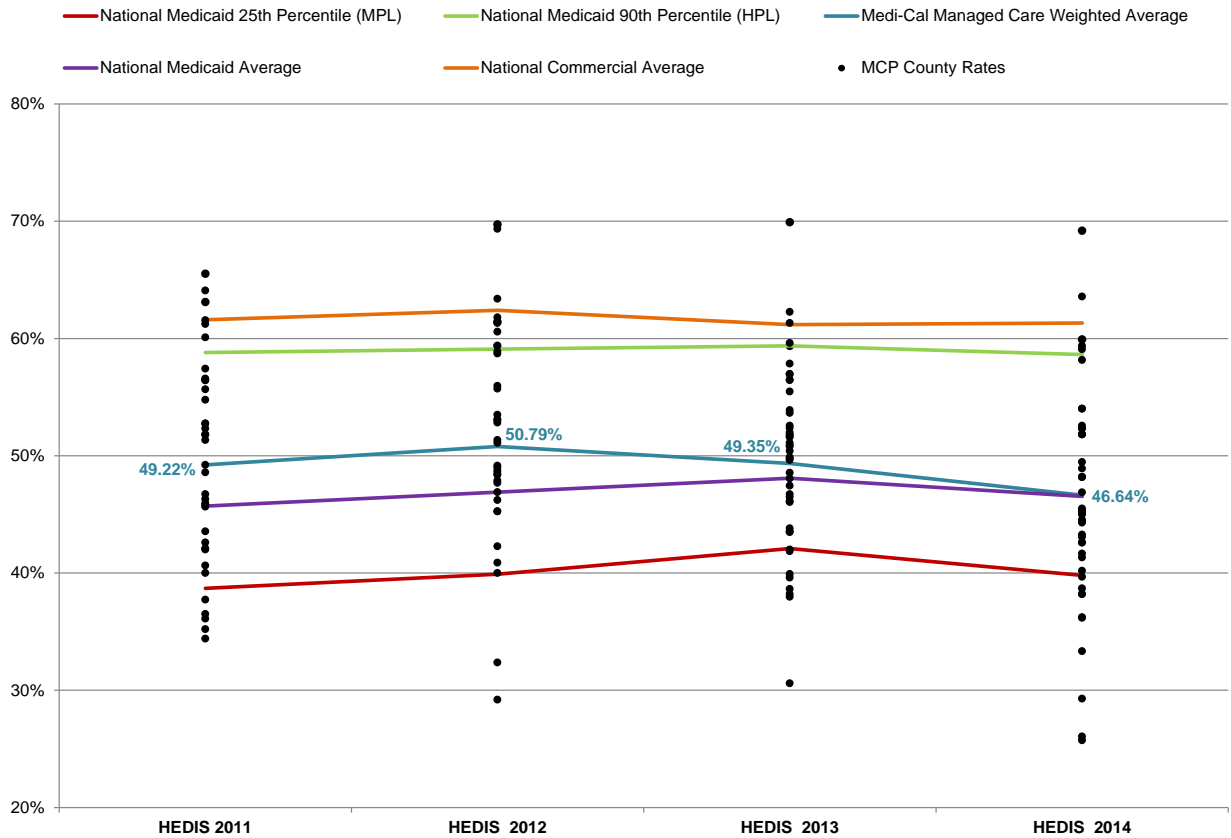
The *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) whose most recent HbA1c test conducted during the year showed an HbA1c level of less than 8 percent.

Importance

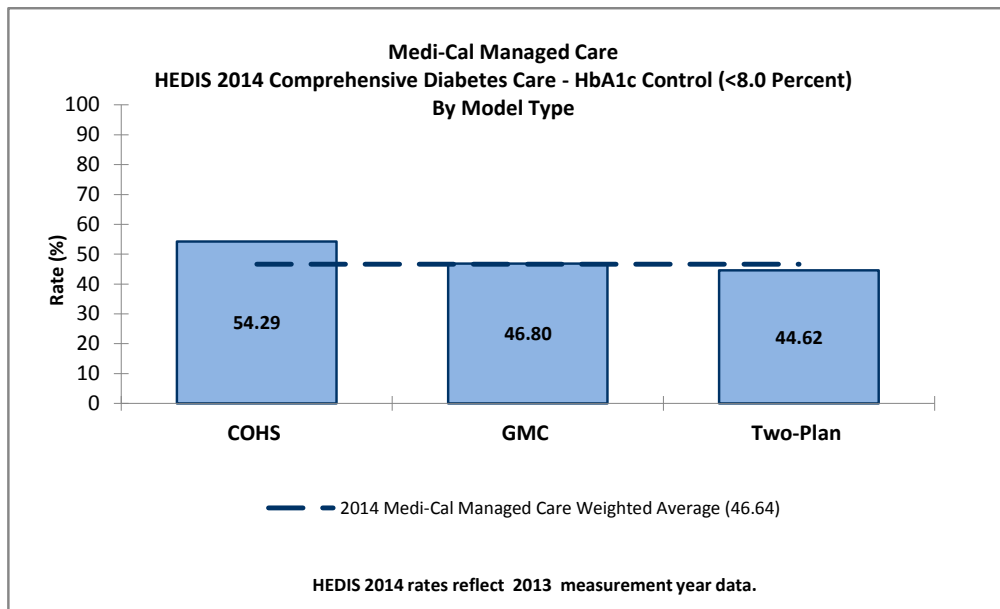
HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Controlling the HbA1c level also lowers the risk of diabetes-related death. In addition, controlling blood glucose levels in people with diabetes significantly reduces the risk of blindness, end-stage renal disease (ESRD), and lower extremity amputation.⁵⁹

⁵⁹ National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.

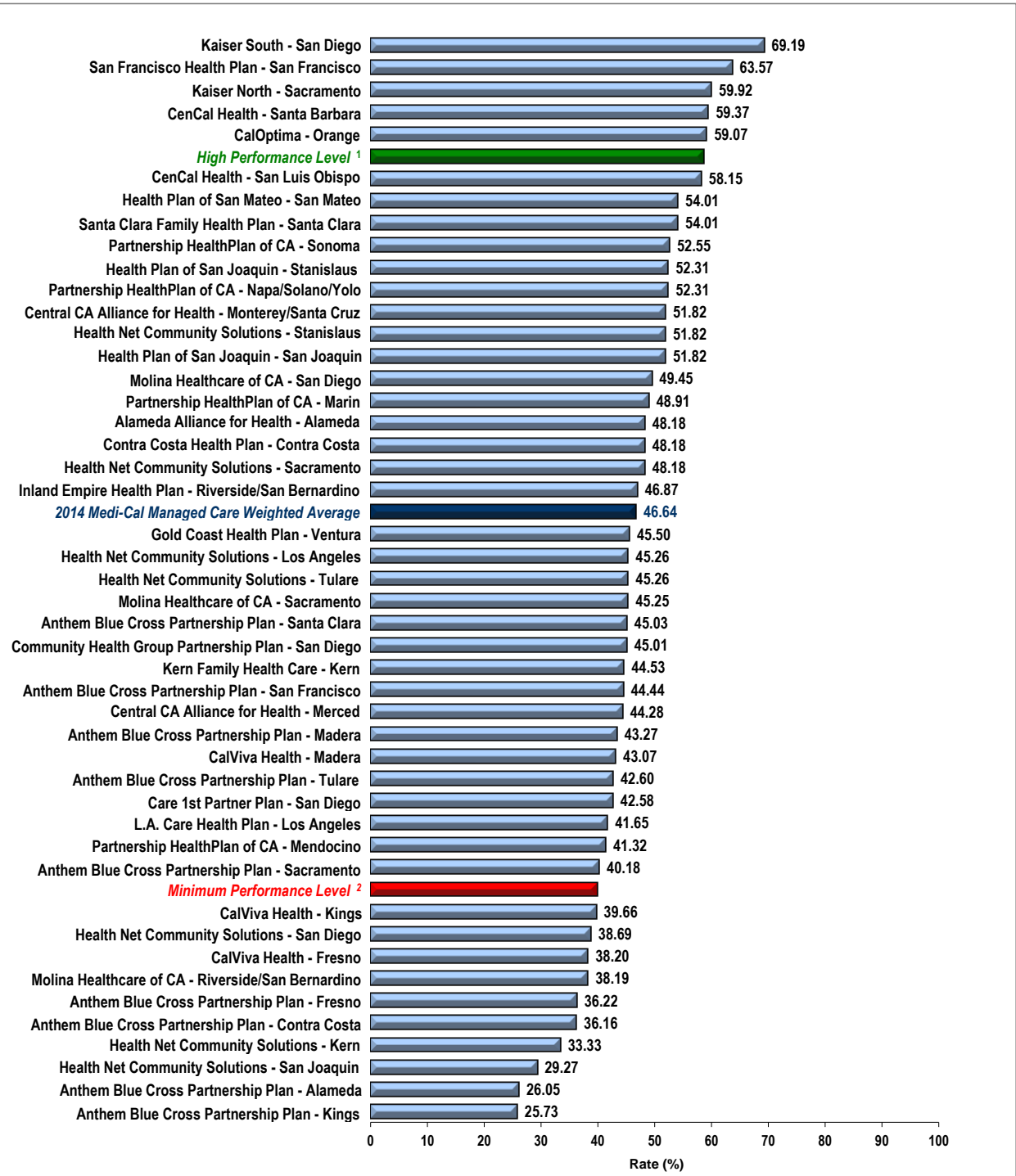
Performance Results—Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)



Note:
 ♦ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
 ♦ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
 ♦ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)

Although the MCMC weighted average for the *Comprehensive Diabetes Care—HbA1c Control* measure declined by almost 3 percentage points from 2013 to 2014, the rate remained above the national Medicaid 25th percentile (MPL) and national Medicaid average for this measure for the fourth consecutive year. The rate has been below the national Medicaid 90th percentile (HPL) and national commercial average for four consecutive years. The COHS model outperformed the TPM and GMC model for the fourth consecutive year.

High and Low Performers

For the fourth consecutive year, the following MCP county rates were above the HPL:

- ◆ CenCal Health—Santa Barbara County
- ◆ Kaiser North—Sacramento County
- ◆ Kaiser South—San Diego County
- ◆ San Francisco Health Plan—San Francisco County

The rate for CalOptima—Orange County was also above the HPL in 2014.

The rate for Gold Coast Health Plan—Ventura County improved significantly from 2013 to 2014, resulting in the rate moving from below the MPL in 2013 to above the MPL in 2014. (Note: 2013 was the first year Gold Coast Health Plan reported a rate for Ventura County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

The rate for Health Net Community Solutions, Inc.—Los Angeles County improved from 2013 to 2014, and although the improvement was not statistically significant, the improvement resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014.

The rates for 10 MCP counties were below the MPL in 2014. (Note: The rate for Health Net Community Solutions, Inc.—San Joaquin County was one of the 10 rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL).

The rates for two of Anthem Blue Cross Partnership Plan’s counties—Alameda and Contra Costa—were below the MPL for the fourth consecutive year. The rates for eight MCP counties declined significantly from 2013 to 2014, and for one of these counties, Health Net Community Solutions, Inc.—San Diego County, the decline resulted in the rate moving from above the MPL in 2013 to below the MPL in 2014. Three MCP county rates with non-statistically significant decline moved from above the MPL in 2013 to below the MPL in 2014:

- ◆ CalViva Health—Fresno County (Note: Since Anthem Blue Cross Partnership Plan did not report rates for Fresno County in 2012, DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).
- ◆ Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino counties

Comprehensive Diabetes Care—HbA1c Testing

Measure Definition

The *Comprehensive Diabetes Care—HbA1c Testing* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who had an HbA1c test during the measurement year.

Importance

Blood tests to measure HbA1c (A1c) levels (glycosylated hemoglobin levels) are critical for diabetics. Diabetics with a high A1c level are at an increased risk of:⁶⁰

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

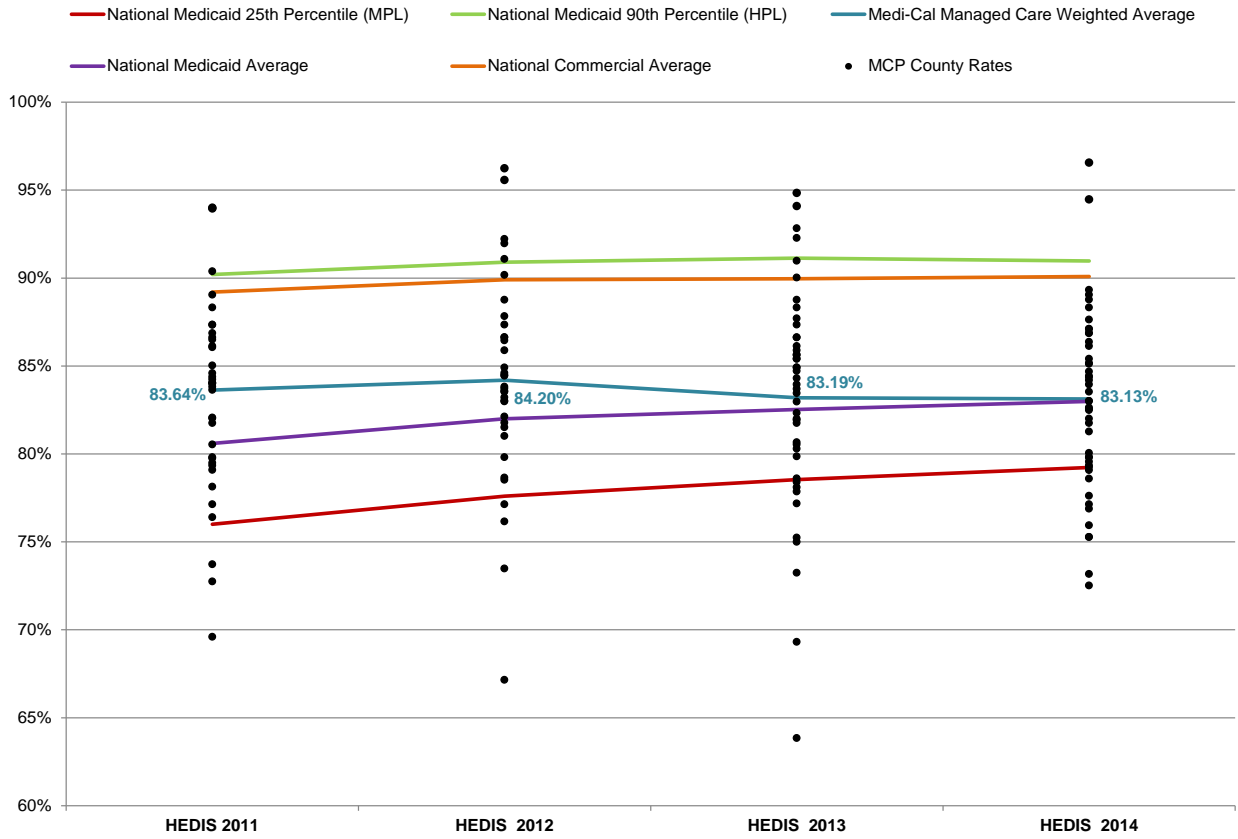
These risks increase if A1c levels are not controlled. The reduction of A1c level by 1 percent decreases the risk of:⁶¹

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

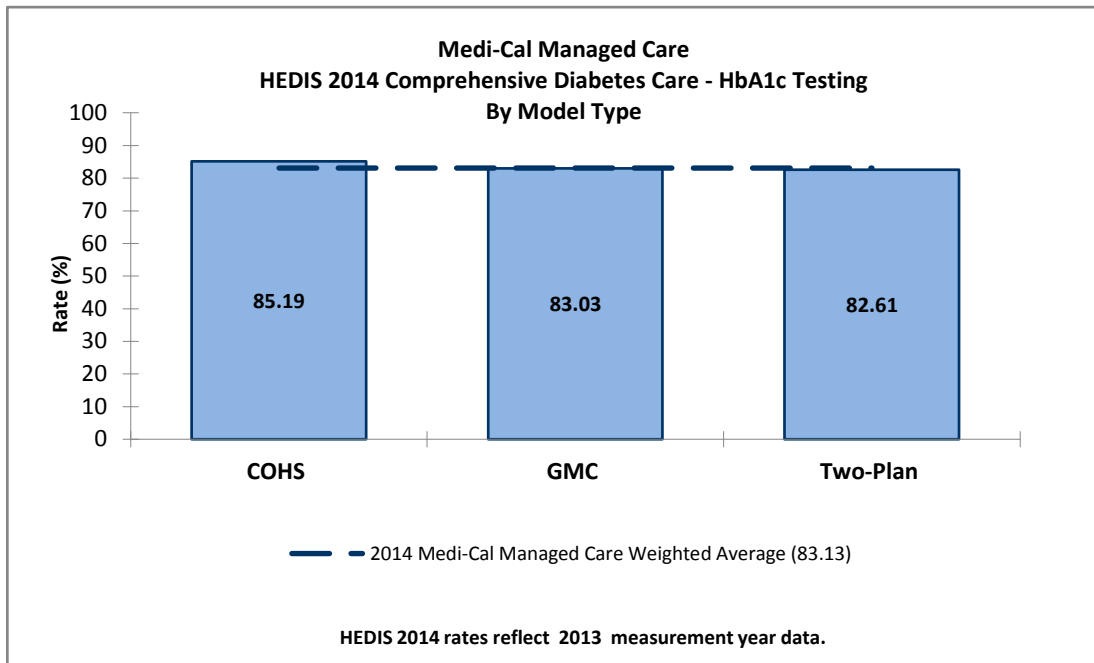
⁶⁰ National Institute of Health. Available at: <http://www.nlm.nih.gov/medlineplus/ency/article/003640.htm> Accessed on: July 31, 2014.

⁶¹ Everybody. Diabetes and HbA1c Testing. Available at: <http://www.everybody.co.nz/page-46cae434-1bb8-4f84-8d15-76be9785eac2.aspx> Accessed on: July 31, 2014.

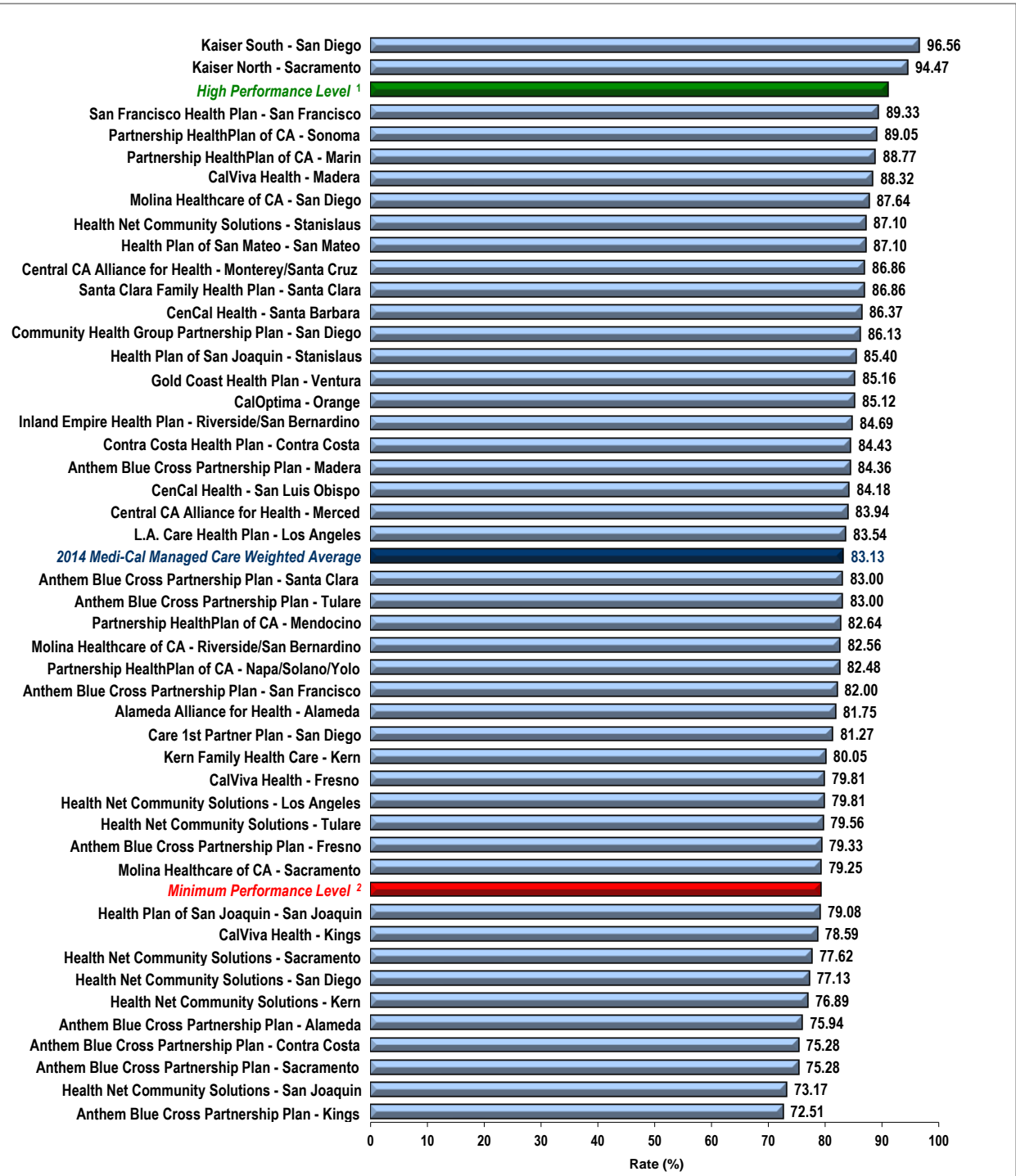
Performance Results—Comprehensive Diabetes Care—HbA1c Testing



Note:
 ♦ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
 ♦ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
 ♦ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Comprehensive Diabetes Care—HbA1c Testing



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.
² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.
 Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Comprehensive Diabetes Care—HbA1c Testing

Although the MCMC weighted average for the *Comprehensive Diabetes Care—HbA1c Testing* measure declined by less than a quarter of a percentage point, the decline resulted in the rate moving from above the national Medicaid average for this measure in 2013 to below the national Medicaid average in 2014. For the fourth consecutive year, the MCMC weighted average remained above the national Medicaid 25th percentile (MPL) and below the national commercial average. The COHS model outperformed the TPM and GMC model in 2014.

High and Low Performers

For the fourth consecutive year, Kaiser North—Sacramento County and Kaiser South—San Diego County had rates above the national Medicaid 90th percentile (HPL). The rate for Anthem Blue Cross Partnership Plan—Alameda County improved significantly from 2013 to 2014; however, the rate remained below the MPL for the fourth consecutive year.

The rates for three MCP counties with non-statistically significant improvement from 2013 to 2014 moved from below the MPL in 2013 to above the MPL in 2014:

- ◆ Anthem Blue Cross Partnership Plan—Fresno County (Note: Since Anthem Blue Cross Partnership Plan did not report rates for Fresno County in 2012, DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).
- ◆ Anthem Blue Cross Partnership Plan—Tulare County
- ◆ Health Net Community Solutions, Inc.—Los Angeles County

The rates for three MCP counties declined significantly from 2013 to 2014:

- ◆ Health Net Community Solutions, Inc.—San Diego County and Tulare County
- ◆ Partnership HealthPlan of California—Mendocino County

The rates for 10 MCP counties were below the MPL in 2014. (Note: The rate for Health Net Community Solutions, Inc.—San Joaquin County was one of the 10 rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL).

The following MCP counties had rates that moved from above the MPL in 2013 to below the MPL in 2014:

- ◆ CalViva Health—Kings County (Note: 2013 was the first year CalViva Health reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).
- ◆ Health Net Community Solutions, Inc.—San Diego County

◆ Health Plan of San Joaquin—San Joaquin County

The rate for Anthem Blue Cross Partnership Plan—Contra Costa County was below the MPL for the fourth consecutive year, and the rate for Anthem Blue Cross Partnership Plan—Sacramento County was below the MPL for the third consecutive year.

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

Measure Definition

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

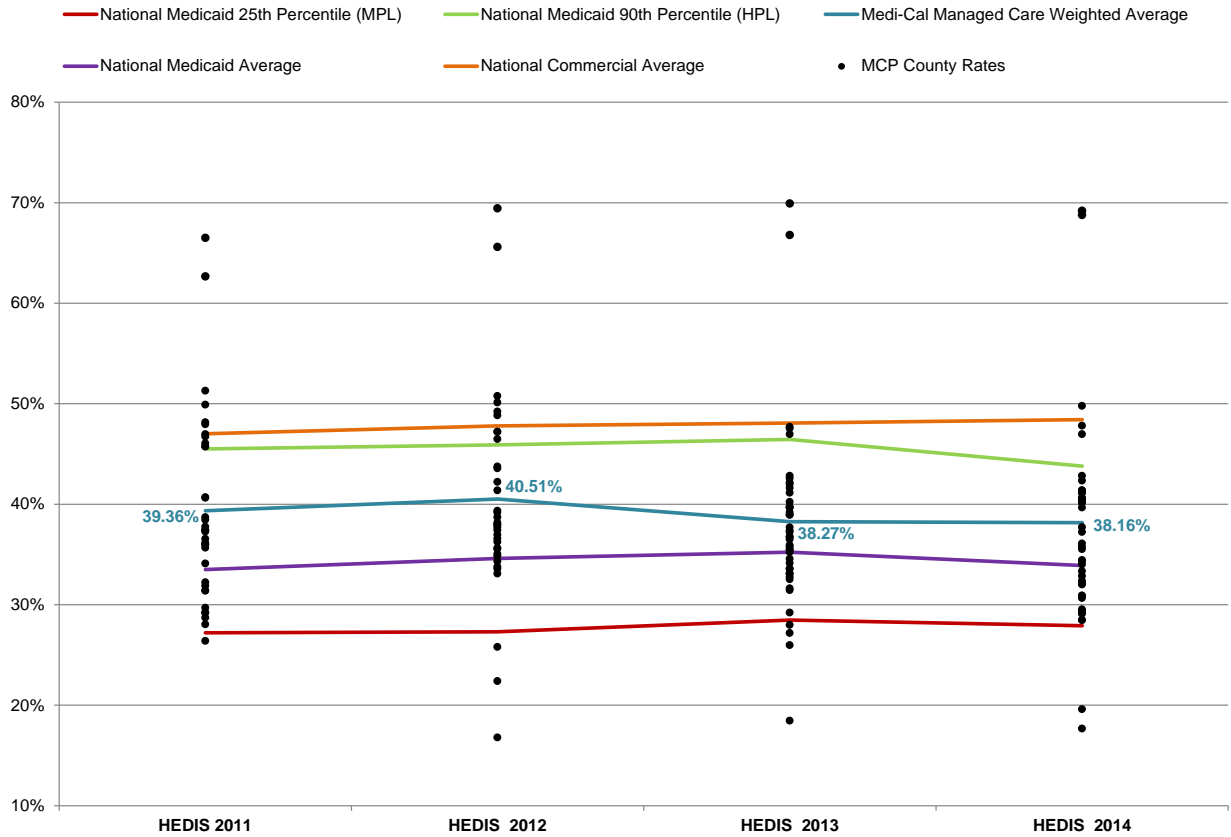
Importance

According to the American Heart Association, 65 percent of patients with diabetes will die from either heart disease or stroke.⁶² Patients can reduce the likelihood of cardiovascular complications by 50 percent just by improving LDL-C levels.⁶³ Therefore, maintaining a desirable LDL-C level is important because it can decrease the risk of cardiovascular complications in individuals with diabetes.

⁶² American Heart Association. Cardiovascular Disease & Diabetes. Available at: http://www.heart.org/HEARTORG/Conditions/Diabetes/WhyDiabetesMatters/Cardiovascular-Disease-Diabetes_UCM_313865_Article.jsp. Accessed on June 12, 2014.

⁶³ National Committee for Quality Assurance. *The State of Health Care Quality 2013*. Washington, D.C.: NCQA; 2013.

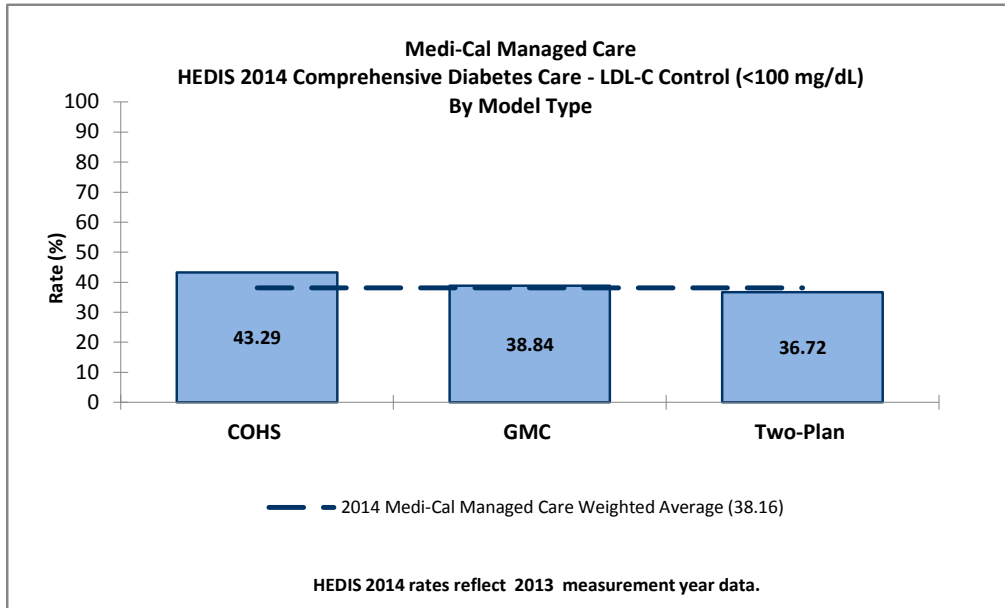
Performance Results—Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)



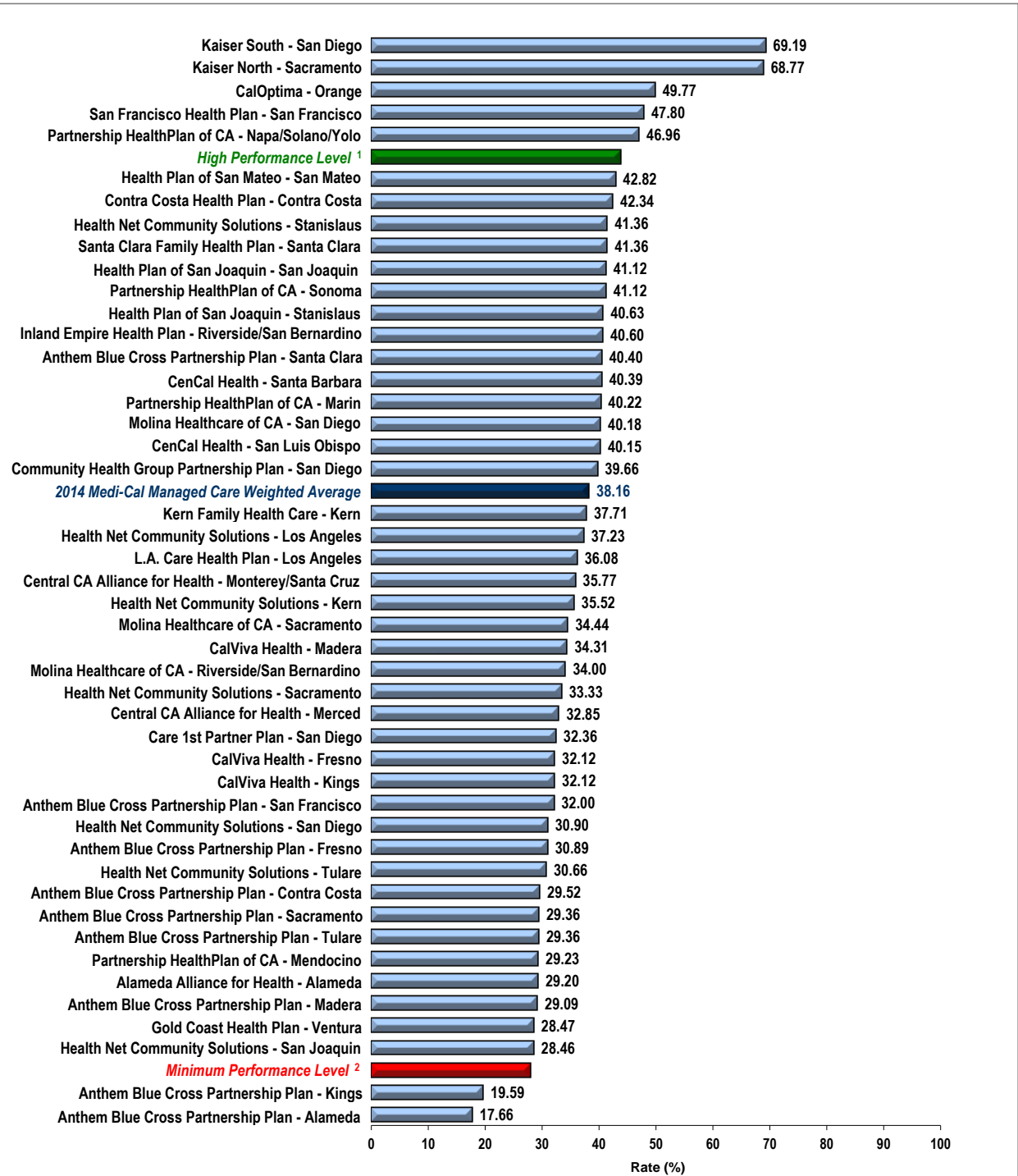
Healthy People 2020 Goal: 58.40%

Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

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

Although an MPL and HPL were established for the *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure, DHCS did not hold MCPs accountable to meet the MPL for HEDIS 2014. NCQA removed this measure from the HEDIS measure set beginning with HEDIS 2015 and as a result, the measure will be removed from the DHCS External Accountability Set (EAS). While the measure will not be a part of the EAS moving forward, HSAG provides a summary of the results for HEDIS 2014 since the MCPs were required to report the measure.

The MCMC weighted average for the *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* measure was above the national Medicaid 25th percentile (MPL) and national Medicaid average for the fourth consecutive year. The rate remained below the national commercial average, national Medicaid 90th percentile (HPL) and Healthy People 2020 goal. The COHS model outperformed the TPM and GMC model for the fourth consecutive year.

High and Low Performers

For the fourth consecutive year, the following MCP county rates were above the HPL:

- ◆ Kaiser North—Sacramento County
- ◆ Kaiser South—San Diego County
- ◆ San Francisco Health Plan—San Francisco County

The rates for CalOptima—Orange County and Health Net Community Solutions, Inc.—Stanislaus County improved significantly from 2013 to 2014, and the improvement for CalOptima—Orange County resulted in the rate being above the HPL. The rate for Partnership HealthPlan of California—Napa/Solano/Yolo counties also was above the HPL in 2014.

The rates for Anthem Blue Cross Partnership Plan—Sacramento County and CalViva Health—Kings County improved from 2013 to 2014, and although the improvement was not statistically significant, the change resulted in the rates improving from below the MPL in 2013 to above the MPL in 2014. (Note: 2013 was the first year CalViva Health reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

The rate for Anthem Blue Cross Partnership Plan—Alameda County was below the MPL for the third consecutive year, and the rate for Anthem Blue Cross Partnership Plan—Kings County also was below the MPL in 2014. The rates for five MCP counties declined significantly from 2013 to 2014.

Comprehensive Diabetes Care—LDL-C Screening

Measure Definition

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

Importance

LDL-C screening is important for diabetics and is used to test cholesterol levels in the blood. High LDL-C levels are associated with increased risk for cardiovascular mortality, heart disease, heart attack, and stroke.⁶⁴

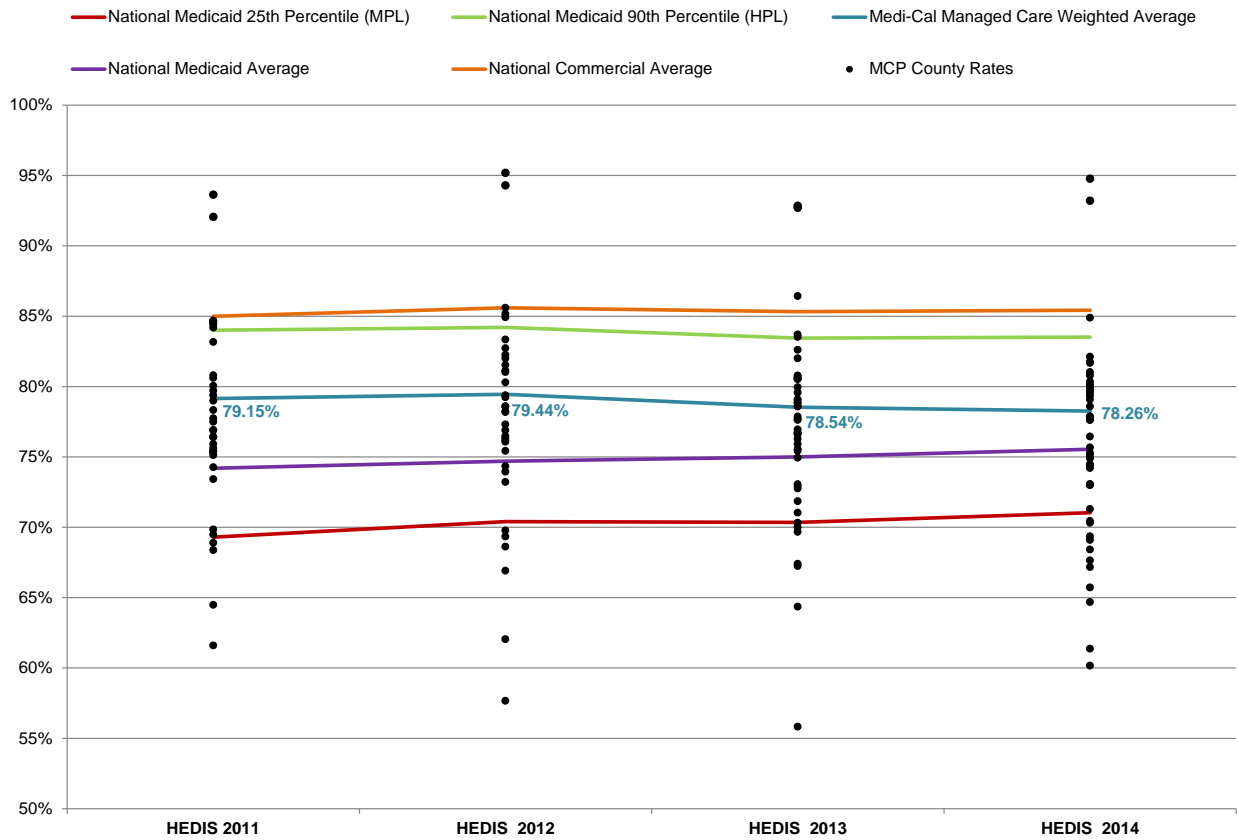
Patients with diabetes are at a two-to-four times greater risk to have heart disease or stroke.⁶⁵ Patients can reduce cardiovascular complications by 50 percent by improving their LDL cholesterol.⁶⁶

⁶⁴ Lab Tests Online. LDL Cholesterol. Available at: <http://www.labtestsonline.org/understanding/analytes/ldl/test.html>. Accessed on: September 11, 2013.

⁶⁵ American Heart Association. Cardiovascular Disease & Diabetes. Available at: http://www.heart.org/HEARTORG/Conditions/Diabetes/WhyDiabetesMatters/Cardiovascular-Disease-Diabetes_UCM_313865_Article.jsp. Accessed on June 12, 2014.

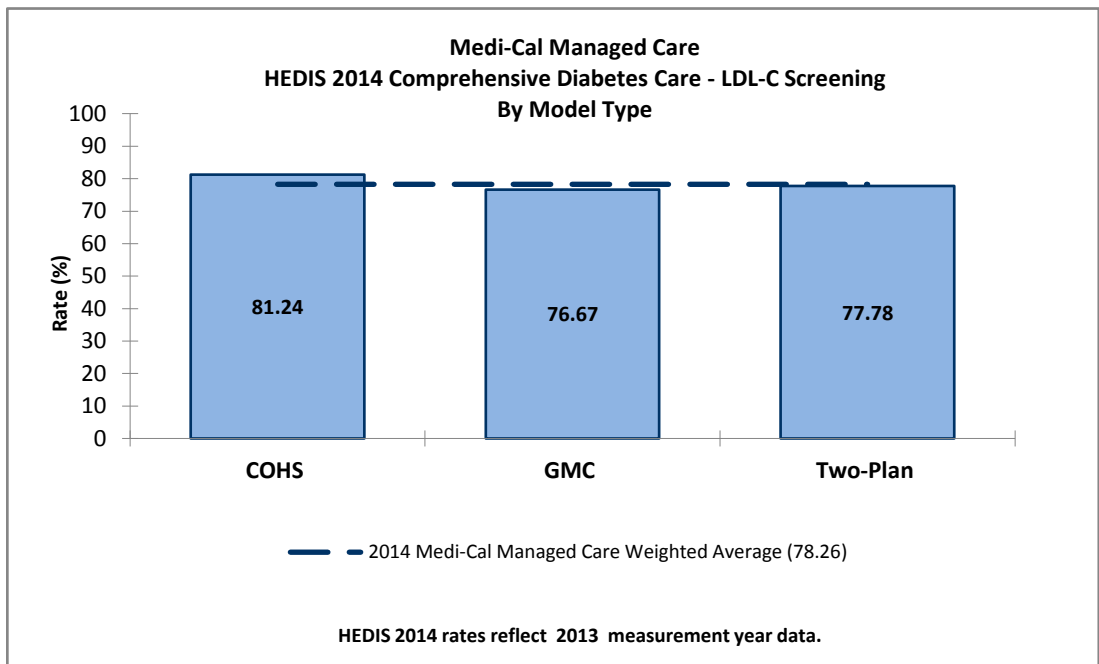
⁶⁶ National Committee for Quality Assurance. *The State of Health Care Quality 2013*. Washington, D.C.: NCQA; 2013.

Performance Results—Comprehensive Diabetes Care—LDL-C Screening

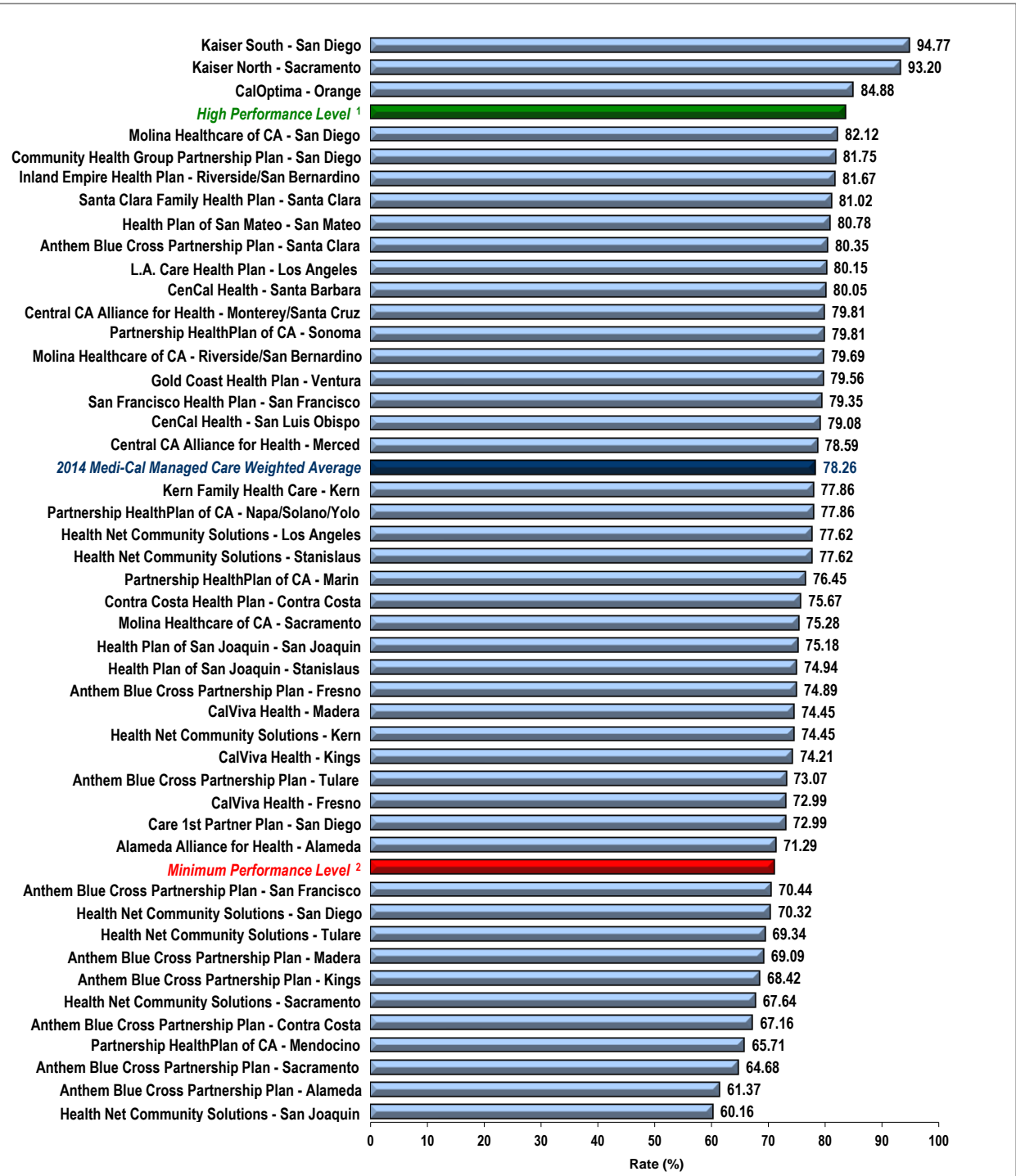


Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Comprehensive Diabetes Care—LDL-C Screening



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.
² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.
 Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Comprehensive Diabetes Care—LDL-C Screening

Although an MPL and HPL were established for the *Comprehensive Diabetes Care—LDL-C Screening* measure, DHCS did not hold MCPs accountable to meet the MPL for HEDIS 2014. NCQA removed this measure from the HEDIS measure set beginning with HEDIS 2015 and as a result, the measure will be removed from the DHCS External Accountability Set (EAS). While the measure will not be a part of the EAS moving forward, HSAG provides a summary of the results for HEDIS 2014 since the MCPs were required to report the measure.

The MCMC weighted average for the *Comprehensive Diabetes Care—LDL-C Screening* measure was above the national Medicaid 25th percentile (MPL) and national Medicaid average for the fourth consecutive year. The rate remained below the national commercial average and national Medicaid 90th percentile (HPL). The COHS model outperformed the TPM and GMC model for the fourth consecutive year.

High and Low Performers

For the fourth consecutive year, Kaiser North—Sacramento County and Kaiser South—San Diego County had rates above the HPL.

The rates for the following MCP counties improved from below the MPL in 2013 to above the MPL in 2014:

- ◆ Anthem Blue Cross Partnership Plan—Tulare County
- ◆ CalViva Health—Madera County (Note: 2013 was the first year CalViva Health reported a rate for Madera County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).
- ◆ Molina Healthcare of California Partner Plan, Inc.—Sacramento County

The rates for 11 MCP counties were below the MPL in 2014. The rates for three of Anthem Blue Cross Partnership Plan's counties—Alameda, Contra Costa, and Sacramento—were below the MPL for the fourth consecutive year. Five MCP county rates declined significantly from 2013 to 2014, and for three of these counties, the decline resulted in the rate moving from above the MPL in 2013 to below the MPL in 2014:

- ◆ Health Net Community Solutions, Inc.—San Diego County and Tulare County
- ◆ Partnership HealthPlan of California—Mendocino County

The rates for three of Anthem Blue Cross Partnership Plan's counties—Kings, Madera, and San Francisco—declined from 2013 to 2014, and although the decline was not statistically significant, the change resulted in the rates moving from above the MPL in 2013 to below the MPL in 2014. (Note: 2013 was the first year Anthem Blue Cross Partnership Plan reported rates for Kings and Madera counties, so DHCS did not hold the MCP accountable to meet the MPL for these counties in 2013).

Comprehensive Diabetes Care—Medical Attention for Nephropathy

Measure Definition

The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure is intended to assess whether diabetic patients are being monitored for nephropathy (kidney disease). It reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who received a screening test or had evidence of nephropathy during the measurement year.

Importance

Nephropathy refers to damage or disease of the kidney. Diabetes has been shown to be a leading cause of kidney failure and ESRD, and 20 to 30 percent of diabetics will develop evidence of nephropathy.⁶⁷ In 2011, 44 percent of all new kidney failure cases were due to diabetes. There were also 228,924 patients either receiving continuous dialysis treatments or who had a kidney transplant.⁶⁸ While there are still large numbers of diabetic patients suffering from kidney disease, current research shows a decline in the number of diabetes-related ESRD cases across all ethnicities, genders, and ages; however, the Hispanic population did not see as much of a decline as other ethnicities.⁶⁹

Nephropathy is also associated with increased risk for hypertension and high cholesterol. Blood sugar control reduces the risk of microalbuminuria (having small amounts of protein in the urine) by one-third and reduces the risk of microalbuminuria progressing by 50 percent. It has also been shown that tight control of blood sugar may even reverse microalbuminuria.⁷⁰

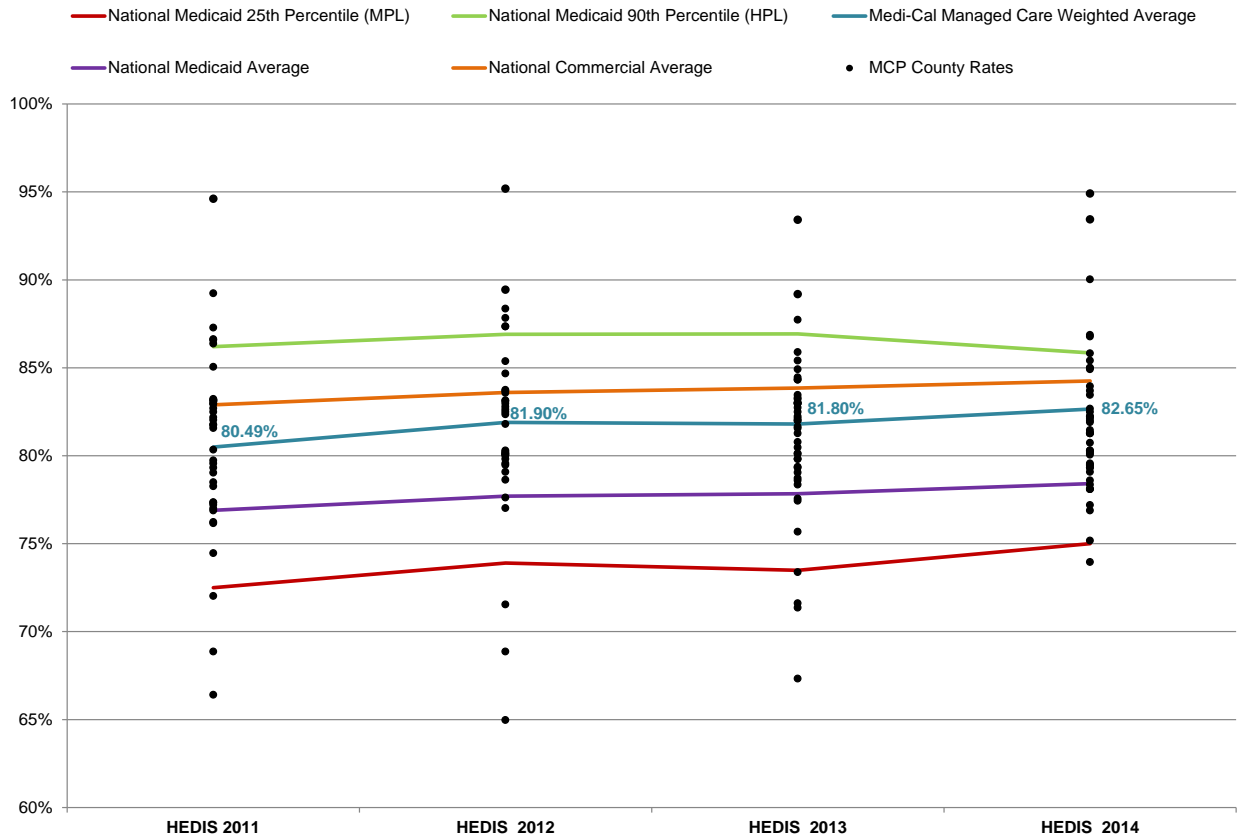
⁶⁷ Butt, Saud, Phillip Hall, and Saul Nurko. Diabetic Nephropathy. *Cleveland Clinic: Center for Continuing Education*. 2010. Available at: <http://www.clevelandclinimed.com/medicalpubs/diseasemanagement/nephrology/diabetic-nephropathy/>. Accessed on: June 13, 2014.

⁶⁸ American Diabetes Association. Statistics About Diabetes. *Overall Numbers, Diabetes and Prediabetes*. 2014. Available at: <http://www.diabetes.org/diabetes-basics/statistics/>. Accessed on: June 13, 2014.

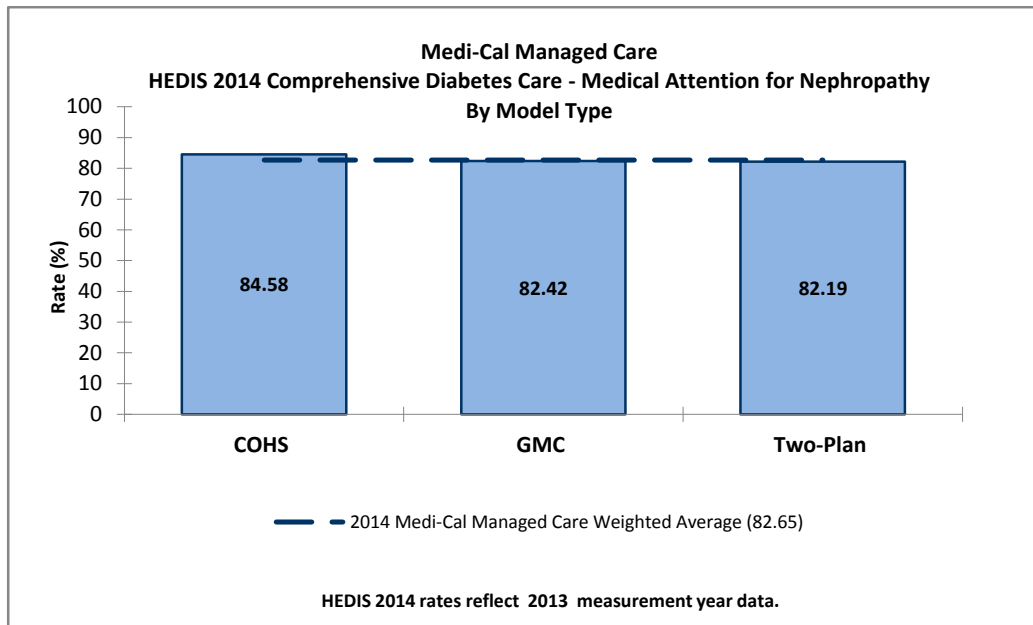
⁶⁹ Burrow, Nilka Rios, Yanfeng Li, and Linda S. Geiss. Epidemiology/Health Services Research. *Incidence of Treatment for End-Stage Renal Disease Among Individuals with diabetes in the U.S. Continues to Decline*. 2010. Available at: <http://care.diabetesjournals.org/content/33/1/73.full.pdf+html>. Accessed on: June 13, 2014.

⁷⁰ National Kidney and Urologic Diseases Information Clearinghouse. *IgA Nephropathy*. Available at: <http://kidney.niddk.nih.gov/kudiseases/pubs/iganephropathy/>. Updated September 2010. Accessed on: September 11, 2013.

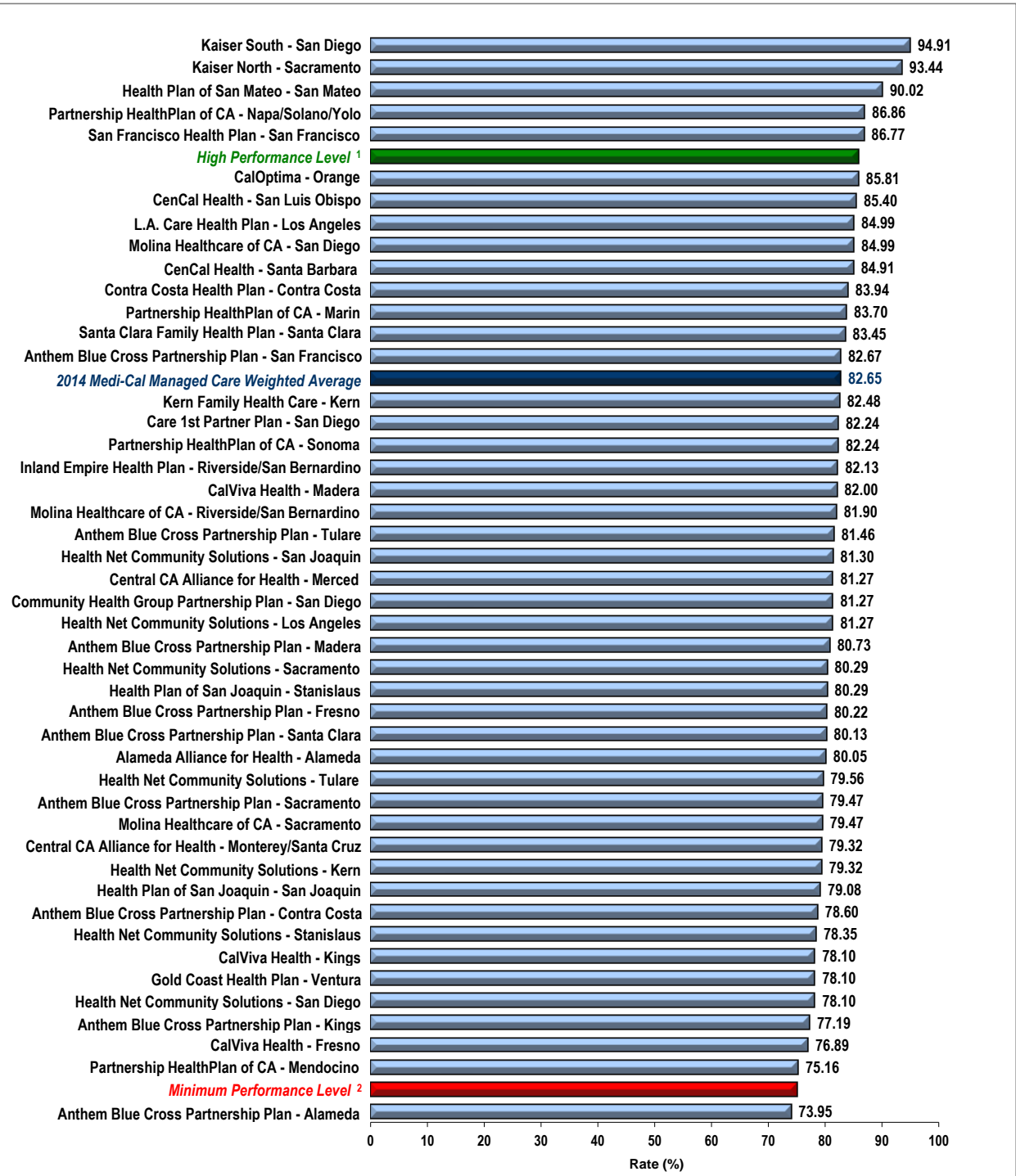
Performance Results—Comprehensive Diabetes Care—Medical Attention for Nephropathy



Note:
 ♦ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
 ♦ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
 ♦ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Comprehensive Diabetes Care—Medical Attention for Nephropathy



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.
² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.
 Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Comprehensive Diabetes Care—Medical Attention for Nephropathy

The MCMC weighted average for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure was above the national Medicaid 25th percentile (MPL) and national Medicaid average for the fourth consecutive year. The rate remained below the national commercial average and national Medicaid 90th percentile (HPL). The COHS model outperformed the TPM and GMC model for the fourth consecutive year.

High and Low Performers

For the fourth consecutive year, the rate for Kaiser South—San Diego County was above the HPL, and Kaiser North—Sacramento County's rate was above the HPL for the third consecutive year. The rates for the following MCP counties also were above the HPL in 2014:

- ◆ Health Plan of San Mateo—San Mateo County
- ◆ Partnership HealthPlan of California—Napa/Solano/Yolo counties
- ◆ San Francisco Health Plan—San Francisco County

The rates for the following MCP counties improved significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—Contra Costa County
- ◆ Anthem Blue Cross Partnership Plan—Sacramento County
- ◆ Health Plan San Mateo—San Mateo County
- ◆ Kaiser North—Sacramento County

The improvement for Anthem Blue Cross Partnership Plan's Contra Costa and Sacramento counties resulted in the rates for these counties moving from below the MPL in 2013 to above the MPL in 2014. The rate for Anthem Blue Cross Partnership Plan—Kings County improved from 2013 to 2014, and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014. (Note: 2013 was the first year Anthem Blue Cross Partnership Plan reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

The only rate below the MPL in 2014 was for Anthem Blue Cross Partnership Plan—Alameda County, and 2014 was the fourth consecutive year the rate was below the MPL.

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

Measure Definition

The *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) whose most recent HbA1c test conducted during the measurement year showed a greater than 9 percent HbA1c level, was missing a result, or if an HbA1c test was not done during the measurement period.

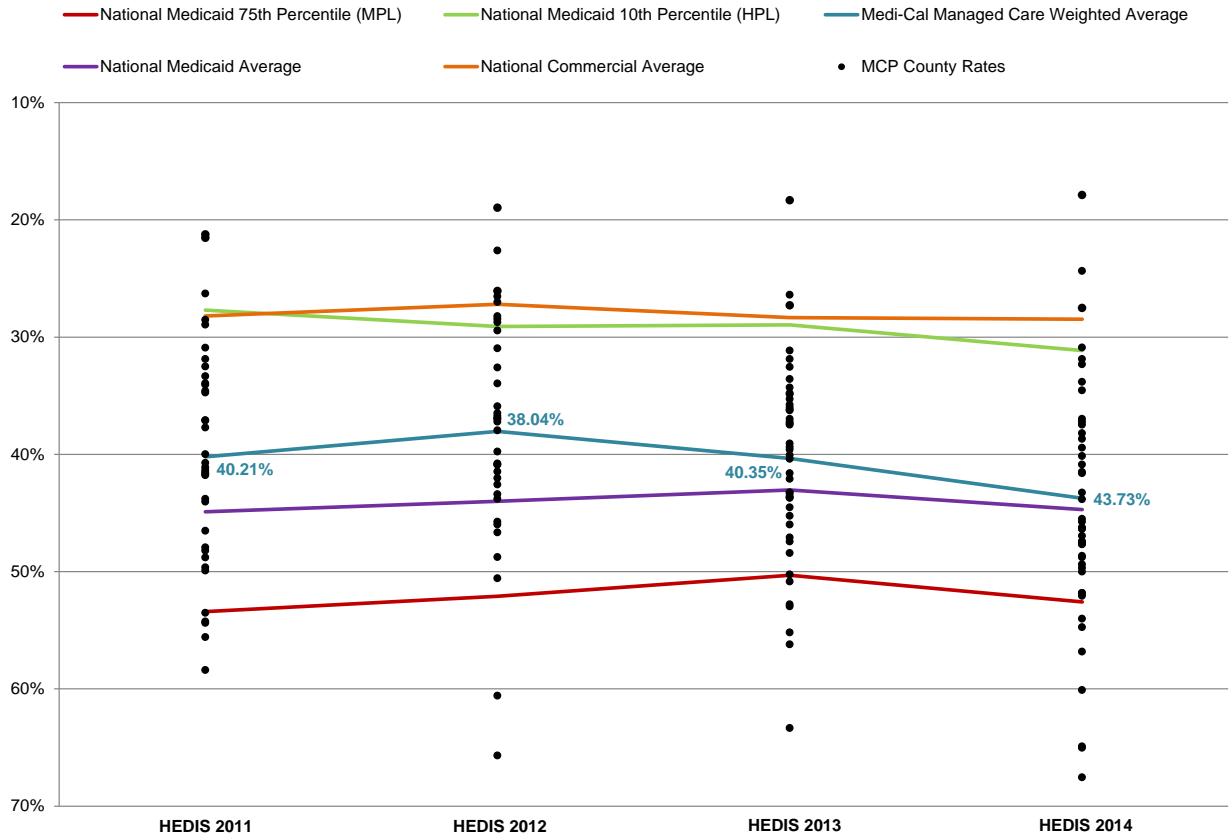
Importance

The United States lost approximately \$245 billion on diabetes medical costs and lost productivity.⁷¹ HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Decreasing the HbA1c level lowers the risk of diabetes-related death. Controlling blood glucose levels in people with diabetes significantly reduces the risk for blindness, heart disease, ESRD, stroke, nerve damage, and lower extremity amputation.⁷²

⁷¹ National Committee for Quality Assurance. *The State of Health Care Quality 2013*. Washington, D.C.: NCQA; 2013.

⁷² National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington, D.C.: NCQA; 2009.

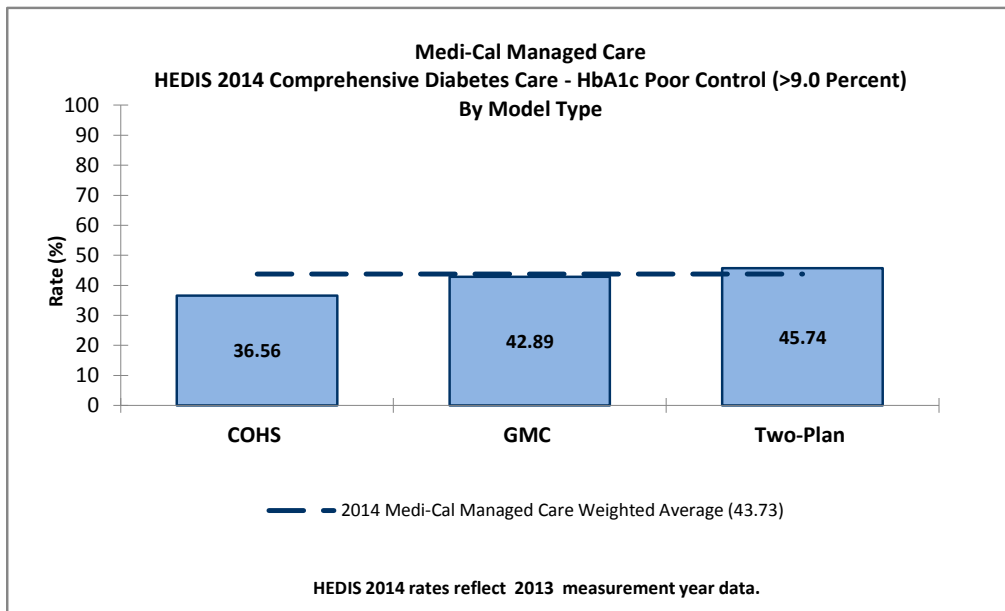
Performance Results—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)



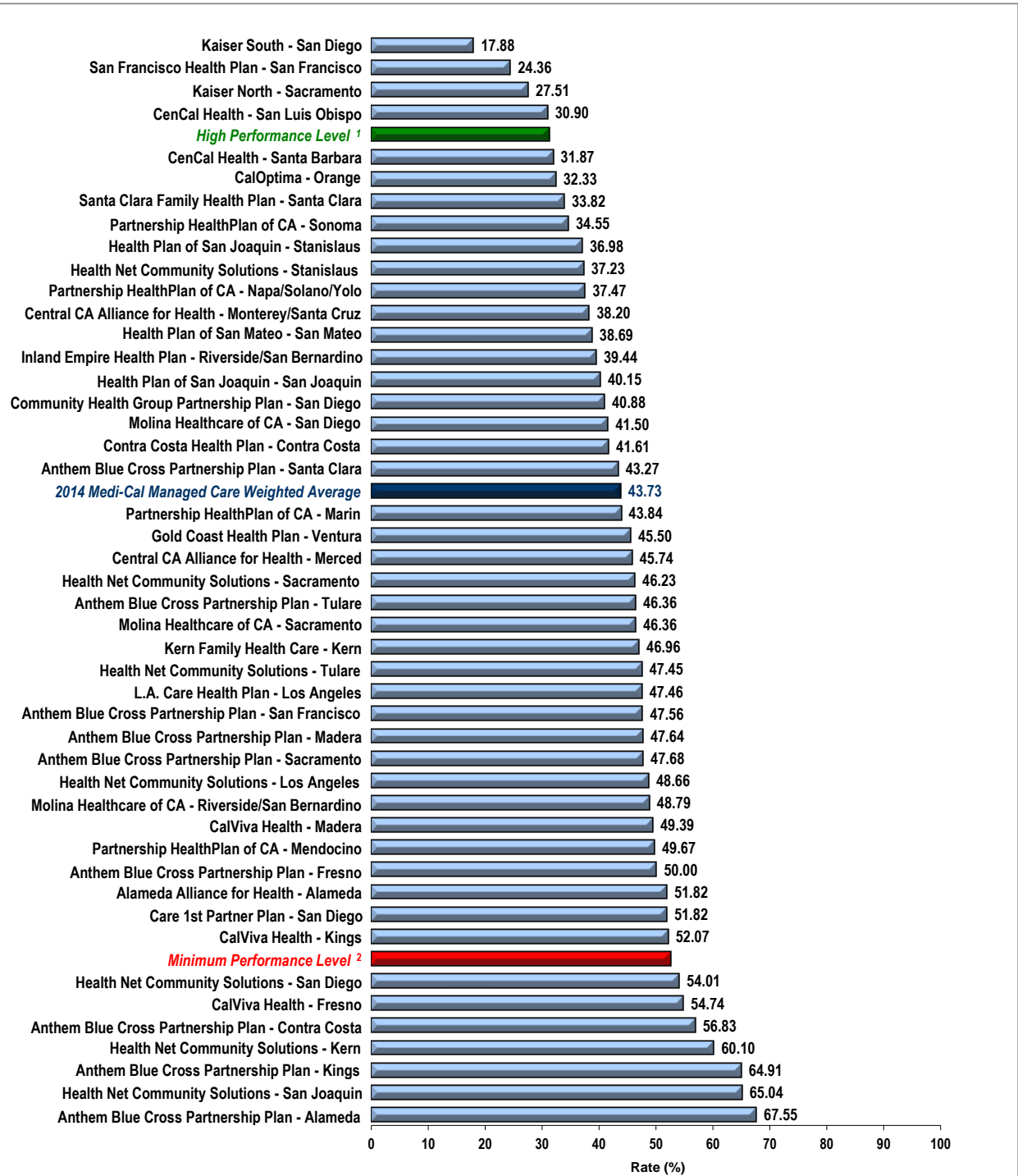
Healthy People 2020 Goal: 16.10%

Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
HEDIS 2014 Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)



¹ High Performance Level is HEDIS 2013 national Medicaid 10th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 75th Percentile.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

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

For the *HbA1c Poor Control (>9.0 Percent)* measure, a lower rate indicates better performance. For the fourth consecutive year, the MCMC weighted average was better (i.e., lower) than the national Medicaid 75th percentile (MPL) and national Medicaid average for this measure and worse (i.e., higher) than the national Medicaid 10th percentile (HPL), national commercial average, and Healthy People 2020 goal. The COHS model outperformed the TPM and GMC model for the fourth consecutive year.

High and Low Performers

For the fourth consecutive year, the rates for the following MCP counties were better than the HPL:

- ◆ Kaiser North—Sacramento County
- ◆ Kaiser South—San Diego County
- ◆ San Francisco Health Plan—San Francisco County

The rate for CenCal Health—San Luis Obispo County also was better than the HPL in 2014.

The rate for Gold Coast Health Plan—Ventura County improved significantly from 2013 to 2014, resulting in the rate moving from higher than the MPL (i.e., worse) to lower than the MPL (i.e., better). (Note: 2013 was the first year Gold Coast Health Plan reported a rate for Ventura County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

The rate for CalViva Health—Kings County improved from 2013 to 2014, and although the improvement was not statistically significant, the rate moved from higher than the MPL to lower than the MPL. (Note: 2013 was the first year CalViva Health reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

The rates for seven MCP counties were higher (i.e., worse) than the MPL in 2014. (Note: The rate for Health Net Community Solutions, Inc.—San Joaquin County was one of the seven rates higher than the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL).

The rates for two of Anthem Blue Cross Partnership Plan’s counties—Alameda and Anthem—were higher than the MPL for the fourth consecutive year. The rates for 11 MCP counties were significantly higher (i.e., worse) in 2014 when compared to 2013, and for two MCP counties, CalViva Health—Fresno County and Health Net Community Solutions, Inc.—San Diego County, the change resulted in their rates moving from lower than the MPL to higher than the MPL.

Best and Emerging Practices—Comprehensive Diabetes Care

MHPA's Center for Best Practices provides information on best practices in the clinical and operations areas of Medicaid health plans. MHPA's *Diabetes Care Best Practices Compendium* provides examples on interventions that have been successful at improving the care provided to Medicaid members with diabetes. MHPA indicates that health plans are using the following approaches to improve diabetes care:⁷³

- ◆ Measuring the quality of care provided to members with diabetes and developing focused efforts to increase evidence-based care.
- ◆ Using care management programs to educate and support patients in making lifestyle choices that prevent and manage diabetes.
- ◆ Engaging members with diabetes or those at risk for diabetes with prevention, treatment, and health education programs.
- ◆ Connecting with members on health education through interactive websites that offer health information, health risk assessments, and games.
- ◆ Offering diabetes disease management directly to patients in need of additional support and education.
- ◆ Contracting with high-quality physicians and increasing patient awareness of high-quality diabetes providers such as those recognized in diabetes care by NCQA.
- ◆ Partnering with physicians and other practitioners to help them understand opportunities to improve diabetes care.
- ◆ Using incentives to encourage members to use high-quality providers and to participate in diabetes management programs.
- ◆ Collaborating with communities and community organizations such as schools, health departments, and fitness organizations to develop prevention and wellness programs.
- ◆ Partnering with states to carry out payment incentive demonstration programs to reward providers for better quality care.

⁷³ Medicaid Health Plans of America: Centers for Best Practices. *Best Practices Compendium on Diabetes Care*. 2013. Available at: <https://www.mhpa.org/upload/Diabetes%20Compendium%20Final%20Web.pdf>. Accessed on: August 14, 2014.

Controlling High Blood Pressure

Measure Definition

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

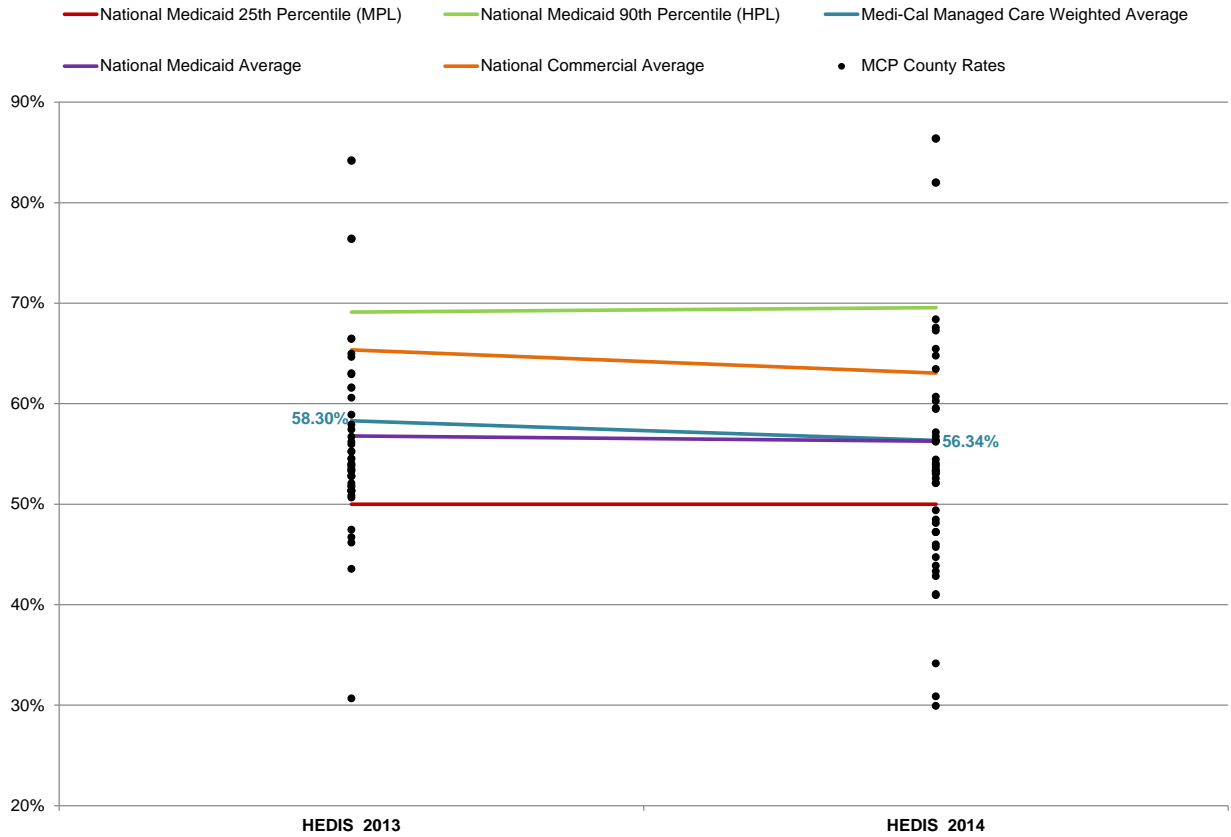
Importance

Although hypertension does not have symptoms, it can lead to increased risk for heart disease and stroke. NCQA has estimated that by 2015, hypertension will cost America \$118.6 billion in both direct and indirect costs. One in three Americans currently has hypertension, but fewer than 50 percent have their disease under control.⁷⁴ Research has shown that by controlling hypertension, mortality from both strokes and coronary heart disease is reduced by 42 percent and 14 to 20 percent respectively. By reducing sodium intake and making lifestyle changes, a person with hypertension can reduce his or her risk of cardiovascular disease and have an overall healthier life.⁷⁵

⁷⁴ National Committee for Quality Assurance. *The State of Health Care Quality 2013*. Washington, D.C: NCQA 2013.

⁷⁵ Agency for Healthcare Research and Quality. *National Quality Measures Clearinghouse*. Available at: <http://www.qualitymeasures.ahrq.gov/content.aspx?id=38869>. Accessed on: June 16, 2014.

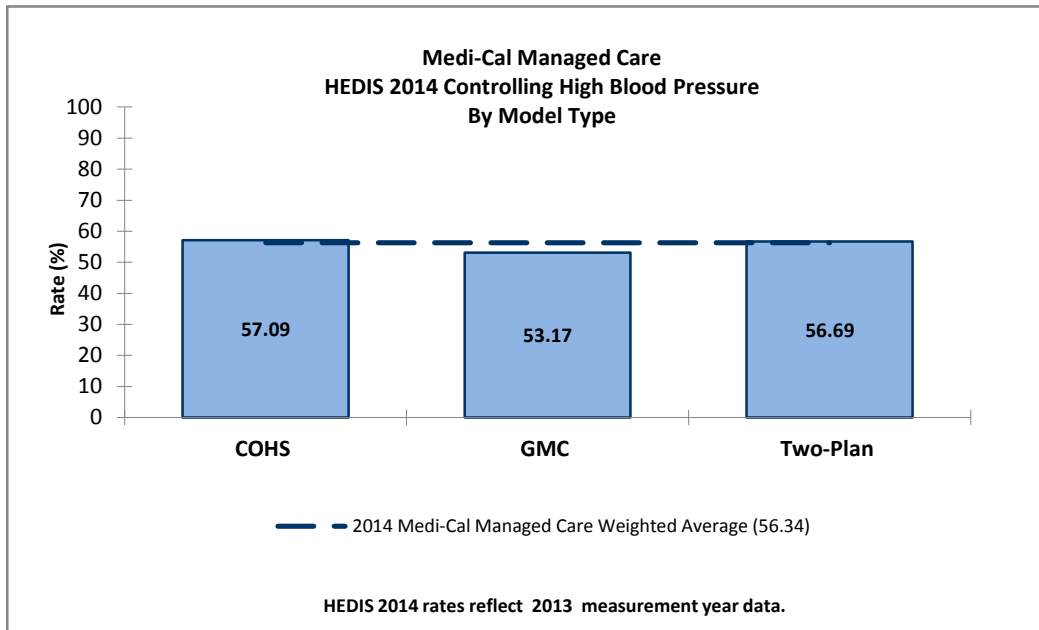
Performance Results—Controlling High Blood Pressure



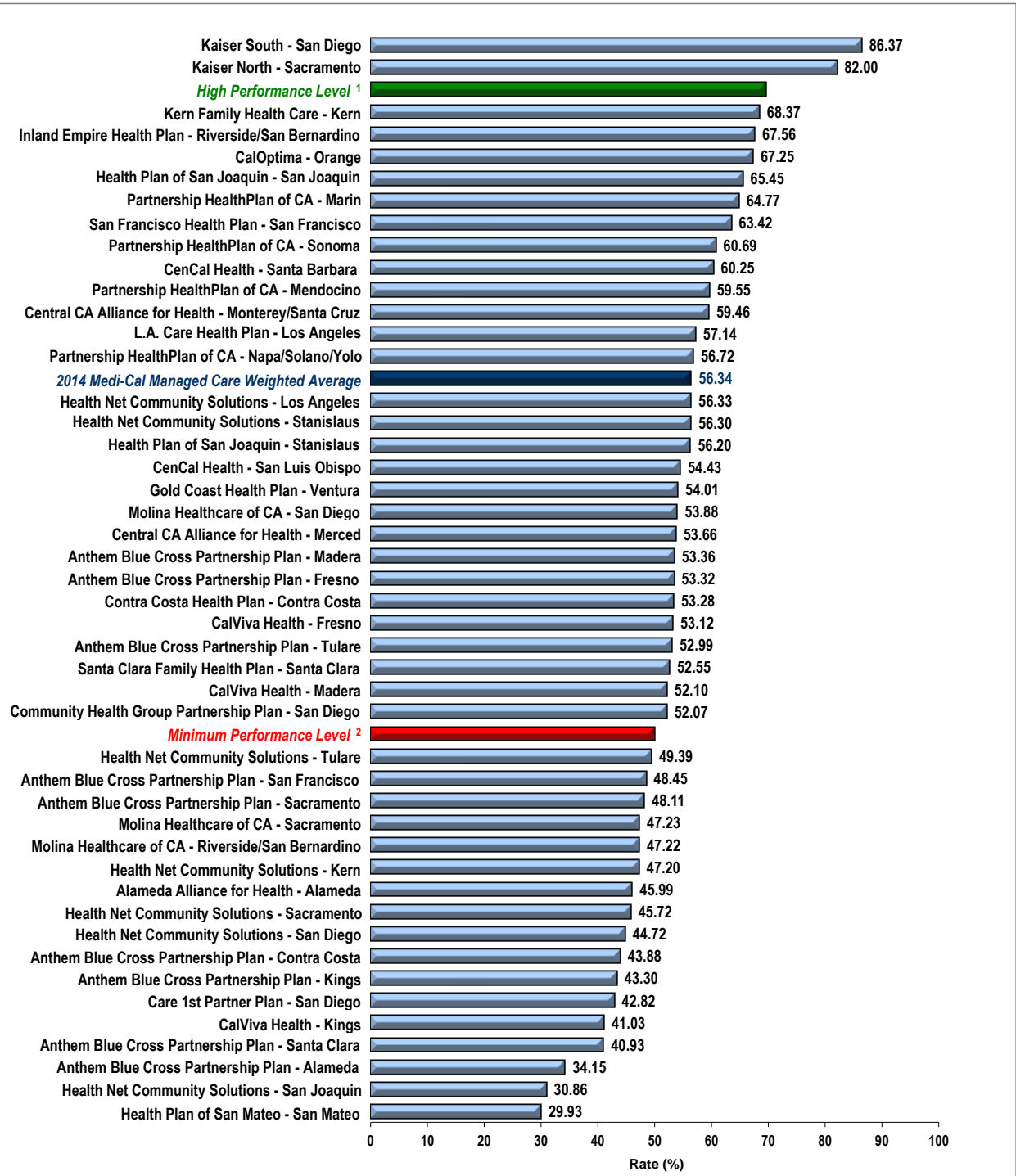
Healthy People 2020 Goal: 61.20%

Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Controlling High Blood Pressure



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.
² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.
 Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Controlling High Blood Pressure

HEDIS 2014 was the first year DHCS held the MCPs accountable to meet the national Medicaid 25th percentile (MPL) for the *Controlling High Blood Pressure* measure since 2013 was the first year the measure was part of DHCS's External Accountability Set (EAS). The 2014 MCMC weighted average for the *Controlling High Blood Pressure* measure was above the MPL and national Medicaid average and below the national commercial average and national Medicaid 90th percentile (HPL). Additionally, the rate was below the Healthy People 2020 goal of 61.20 percent. The COHS model performed less than one-half percentage point better than the TPM and outperformed the GMC model by almost 4 percentage points.

High and Low Performers

The rates for Kaiser North—Sacramento County and Partnership HealthPlan of California—Marin County improved significantly from 2013 to 2014, and the rates for Kaiser North—Sacramento County and Kaiser South—San Diego County were above the HPL in 2014. The rates for 17 MCP counties were below the MPL, and nine MCP county rates declined significantly from 2013 to 2014. The significant decline resulted in the rates for seven MCP counties moving from above the MPL in 2013 to below the MPL in 2014. Additionally, three MCP county rates with non-statistically significant decline moved from above the MPL in 2013 to below the MPL in 2014:

- ◆ Health Net Community Solutions, Inc.—Kern County and Tulare County
- ◆ Molina Healthcare of California Partner Plan, Inc.—Sacramento County

Note: The rate for Health Net Community Solutions, Inc.—San Joaquin County was one of the 17 rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL.

Best and Emerging Practices—Controlling High Blood Pressure

The Community Preventive Services Task Force found strong scientific evidence that lowering out-of-pocket medication costs for patients with high blood pressure and high cholesterol can help control both conditions.⁷⁶ The Task Force recommends combining the reduction in out-of-patient costs with additional interventions aimed at improving patient-provider interaction and patient knowledge. The recommendation is based on strong evidence that this approach improves medication adherence and blood pressure and cholesterol outcomes.

⁷⁶ Community Preventive Services Task Force. Community Guide News. Available at: <http://www.thecommunityguide.org/news/2013/CVD-ROPC.html>. Accessed on August 10, 2014.

The Community Preventive Services Task Force also recommends a team-based care approach to improving blood pressure control.⁷⁷ The intervention is a health systems-level, organizational approach that incorporates a multidisciplinary team to improve the quality of hypertension care for patients. Each team includes the patient, the patient's PCP, and other professionals such as nurses, pharmacists, dieticians, social workers, and community health workers. Team members provide support and share the responsibilities of the hypertension care to complement the activities of the PCP. The responsibilities include medication management, patient follow-up, and adherence and self-management support. The recommendation is based on strong evidence of effectiveness in improving the proportion of patients with controlled blood pressure in reducing systolic and diastolic blood pressure. Additionally, the evidence indicates that team-based care is cost effective.

⁷⁷ Community Preventive Services Task Force. *Cardiovascular Disease Prevention and Control: Team-Based Care to Improve Blood Pressure Control*. Available at: <http://www.thecommunityguide.org/cvd/teambasedcare.html>. Accessed on August 10, 2014.

Immunizations for Adolescents—Combination 1

Measure Definition

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

Importance

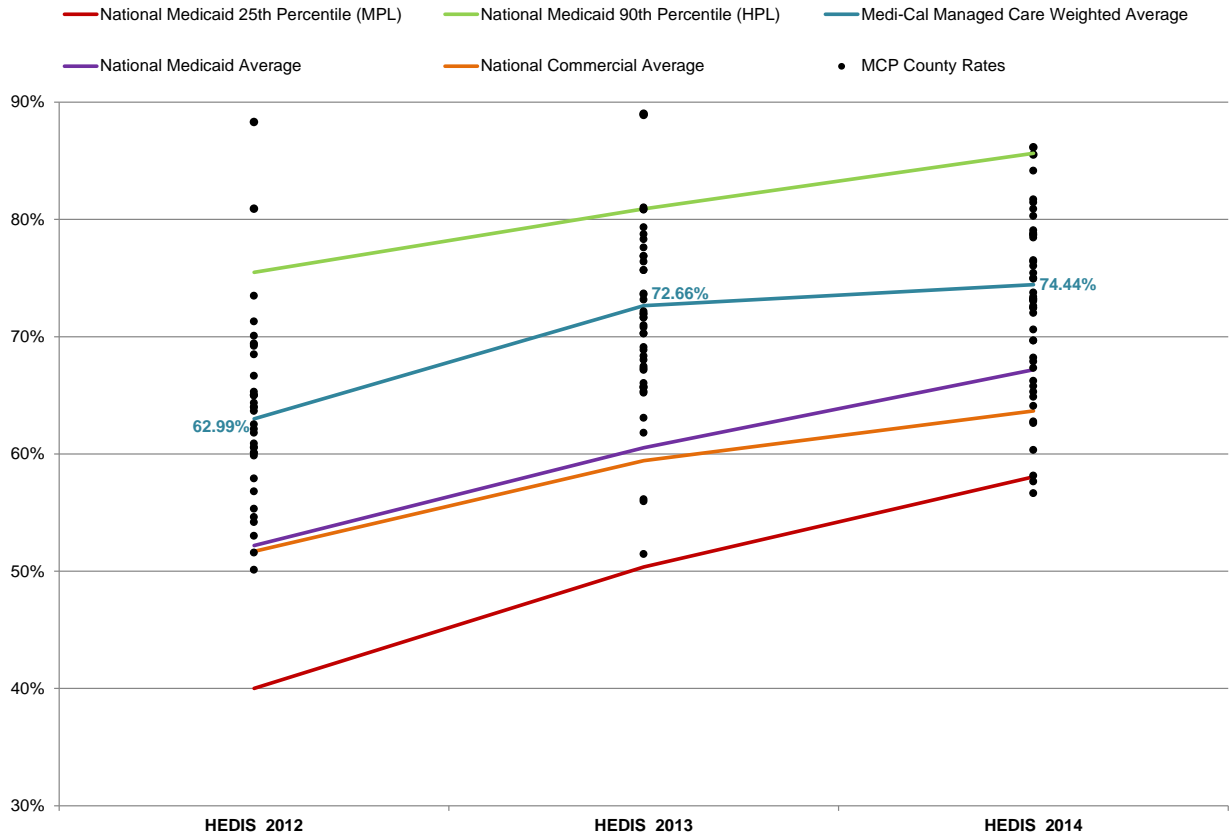
As children grow into adolescents, they will need to update the vaccinations they received as children with booster shots and receive new vaccines targeted specifically to adolescents. By not continuing with recommended vaccinations, adolescents have the potential to cause outbreaks of preventable diseases and establish reservoirs of disease in adolescents that can affect other populations, including infants, the elderly, and individuals with chronic conditions. In 2012, a pertussis outbreak resulted in 32,000 cases and 16 deaths nationwide.⁷⁸ The CDC indicated that in 2012, adolescents aged 13–15 years old received the meningococcal and Tdap vaccine at a rate of 73.8 percent and 85.3 percent, respectively.⁷⁹ Although progress has been made, many adolescents still lack the life-saving coverage vaccines provide.

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

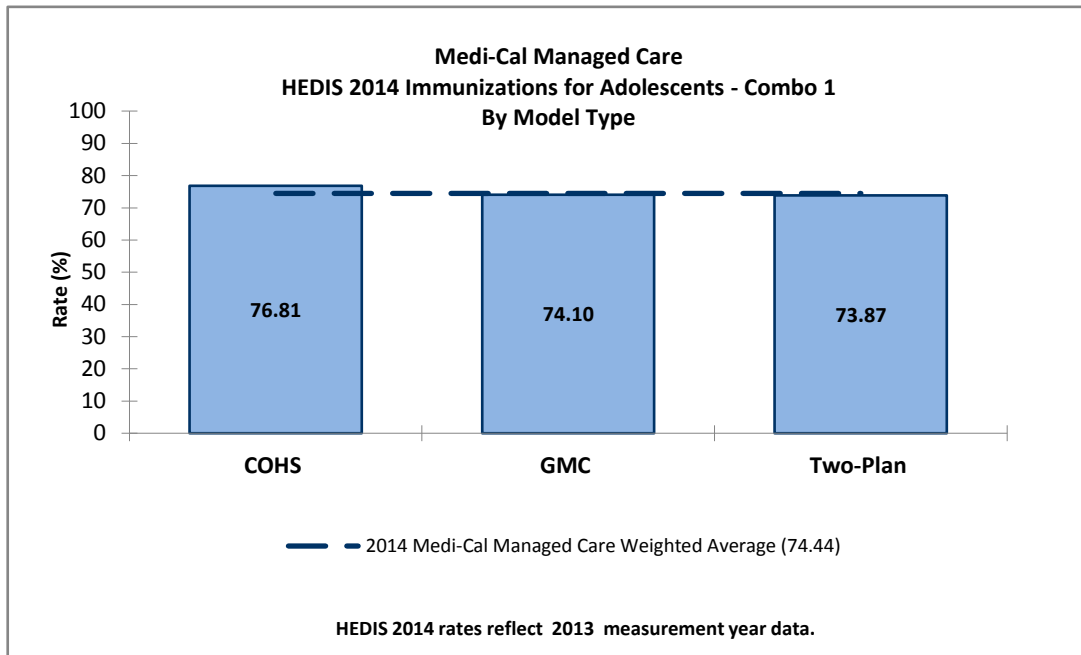
⁷⁸ National Committee for Quality Assurance. *The State of Health Care Quality 2013*. Washington, D.C: NCQA 2013.

⁷⁹ Centers for Disease Control and Prevention. *National and State Vaccination Coverage Among Adolescents Aged 13–17 Years—United States, 2012*. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6234a1.htm>. Accessed on: June 16, 2014.

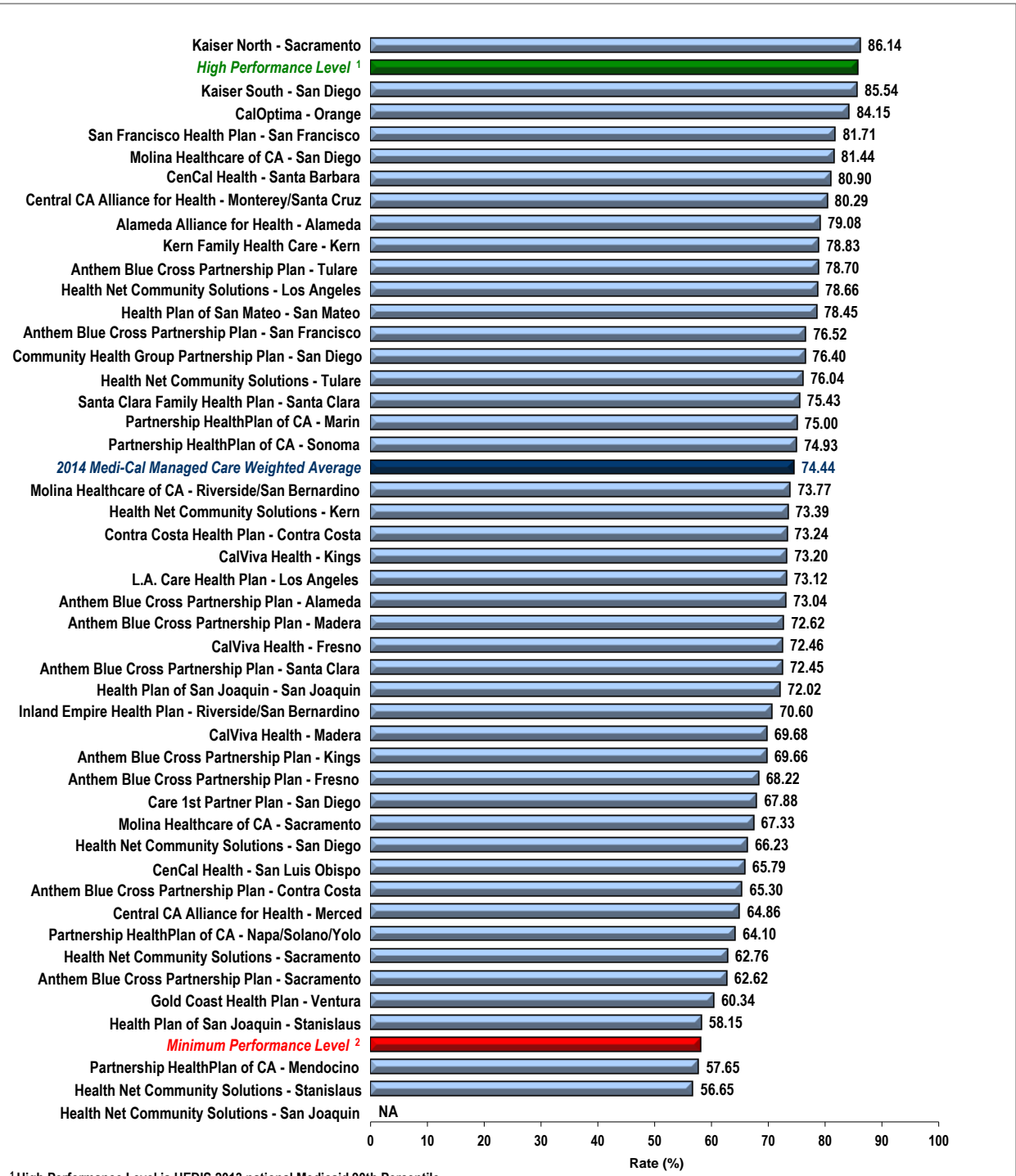
Performance Results—Immunizations for Adolescents—Combination 1



Note:
 ♦ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
 ♦ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
 ♦ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Immunizations for Adolescents—Combination 1



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

NA = A Not Applicable audit finding because the MCP's denominator was too small (i.e., less than 30).

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Immunizations for Adolescents—Combination 1

For the third consecutive year, the MCMC weighted average for the *Immunizations for Adolescents—Combination 1* measure was above the national Medicaid 25th percentile (MPL) and national Medicaid and commercial averages for the measure. The rate remained below the national Medicaid 90th percentile (HPL). The COHS model outperformed the TPM and GMC model.

High and Low Performers

The rates for six MCP counties improved significantly from 2013 to 2014, and for the third consecutive year, the rate for Kaiser North—Sacramento County was above the HPL.

The rates for two of Health Net Community Solutions, Inc.'s counties—San Diego and Stanislaus—declined significantly from 2013 to 2014, and the decline in Stanislaus County resulted in the rate moving from above the MPL in 2013 to below the MPL in 2014. The rate for Partnership HealthPlan of California—Mendocino County was the only other rate below the MPL in 2014.

Health Net Community Solutions—San Joaquin County had an audit result of “NA” for this measure, meaning that although the MCP complied with all applicable specifications, it had a denominator less than 30 for the measure, resulting in the “NA” audit result.

Best and Emerging Practices—Immunizations for Adolescents—Combination 1

As indicated in the *Childhood Immunization Status—Combination 3* section, the following types of interventions and strategies recommended by the Community Preventive Services Task Force have been shown to increase the vaccination rates among a wide range of the population:⁸⁰

- ◆ Home visits
- ◆ Reducing client out-of-pocket costs
- ◆ Vaccination programs in schools and child care centers
- ◆ Vaccination programs in the WIC Program
- ◆ Member incentives
- ◆ Member reminder systems
- ◆ Community-based interventions
- ◆ Vaccination requirements for child care and schools

⁸⁰ The Community Guide: Increasing Appropriate Vaccination. Available at <http://www.thecommunityguide.org/vaccines/index.html> Accessed on: July 17, 2014.

- ◆ Immunization information systems
- ◆ Provider assessment and feedback
- ◆ Provider reminders
- ◆ Standing orders

The American Academy of Pediatrics recommends the following strategies for pediatricians for increasing adolescent immunization rates:⁸¹

- ◆ Implementing patient reminder-recall systems.
- ◆ Implementing provider prompts through electronic health records or notes in charts or standing orders for immunizations.
- ◆ Making strong recommendations to parents for all vaccines on the schedule rather than just mentioning that the vaccines are available.
- ◆ Including all recommended vaccinations at every visit.
- ◆ Developing a process to assess the immunization rate for the provider practice and compare the rate to national, state, or local data from the National Immunization Survey.
- ◆ Identifying an immunization champion in the provider practice who can serve as a steward and advocate of immunizations in the practice.
- ◆ Educating patients and their parents about each recommended vaccine and the disease it prevents.
- ◆ Discussing the costs associated with the recommended vaccines and providing information about payment options, if needed.
- ◆ Holding vaccine clinics at hours that are convenient for families (i.e., evenings or Saturdays.)

⁸¹ American Academy of Pediatrics. *AAP Immunization Resources, Adolescent Immunizations: Strategies for Increasing Coverage Rates*. Available at: [AAP Immunization Resources/Adolescent Immunizations/Strategies for Increasing Coverage Rates](#). Accessed on: August 11, 2014.

Medication Management for People with Asthma

Measure Definition

The *Medication Management for People with Asthma* measure is used to assess the percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and who were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

- ◆ The percentage of members who remained on an asthma controller medication for at least 50 percent of their treatment period.
- ◆ The percentage of members who remained on an asthma controller medication for at least 75 percent of their treatment period.

Importance

Effective asthma management depends not only on the availability of prescribed medications, but also on their acceptance and regular use by patients. Current adherence rates to controller medications are extremely low. Only a third (33.5 percent) of patients who require a prescription for inhaled corticosteroids have such a prescription, and only a minority of patients use their preventive medication as directed.⁸² According to NCQA, 70 percent of adults and children who display asthma symptoms are considered "not well controlled" or "very poorly controlled" as defined by clinical practice guidelines.⁸³

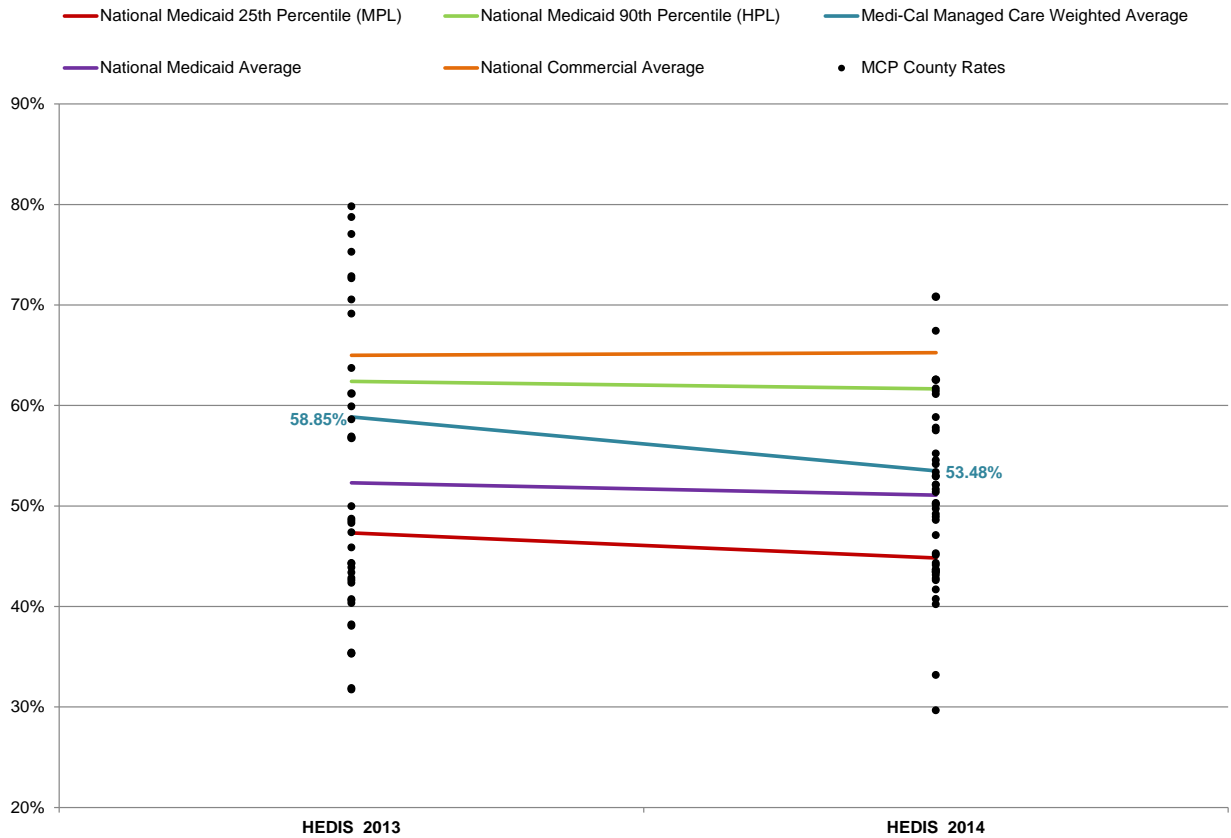
The United States spends approximately \$56 billion per year in direct and indirect medical costs due to asthma-related illness, and approximately 80 percent of this amount is spent on hospitalizations and emergency department visits.⁸⁴ Appropriate medication adherence can decrease the severity of many asthma-related symptoms. Medication management is used to prevent and control asthma symptoms, improve quality of life, reduce the frequency and severity of asthma exacerbations, and reverse airflow obstruction.

⁸² Centers for Disease Control and Prevention, National Center for Health Statistics. *Vital Signs: Asthma Prevalence, Disease Characteristics, and Self-Management Education – United States, 2001–2009*. 2011.

⁸³ National Committee for Quality Assurance. *The State of Health Care Quality 2013*. Washington, D.C: NCQA. 2013.

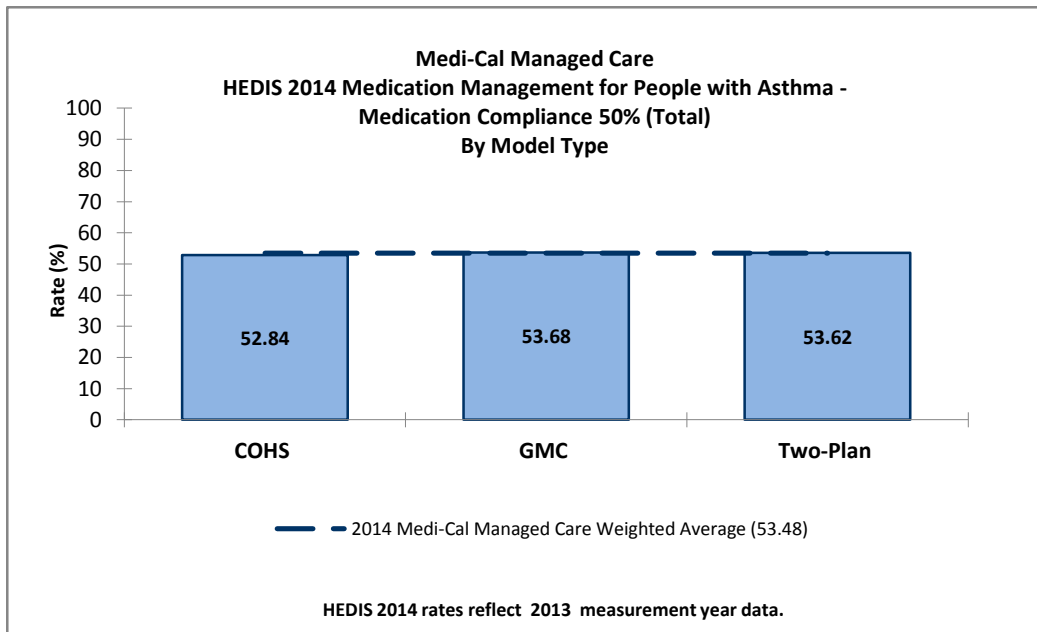
⁸⁴ Ibid.

**Performance Results—Medication Management for People with Asthma—
Medication Compliance 50% (Total)**



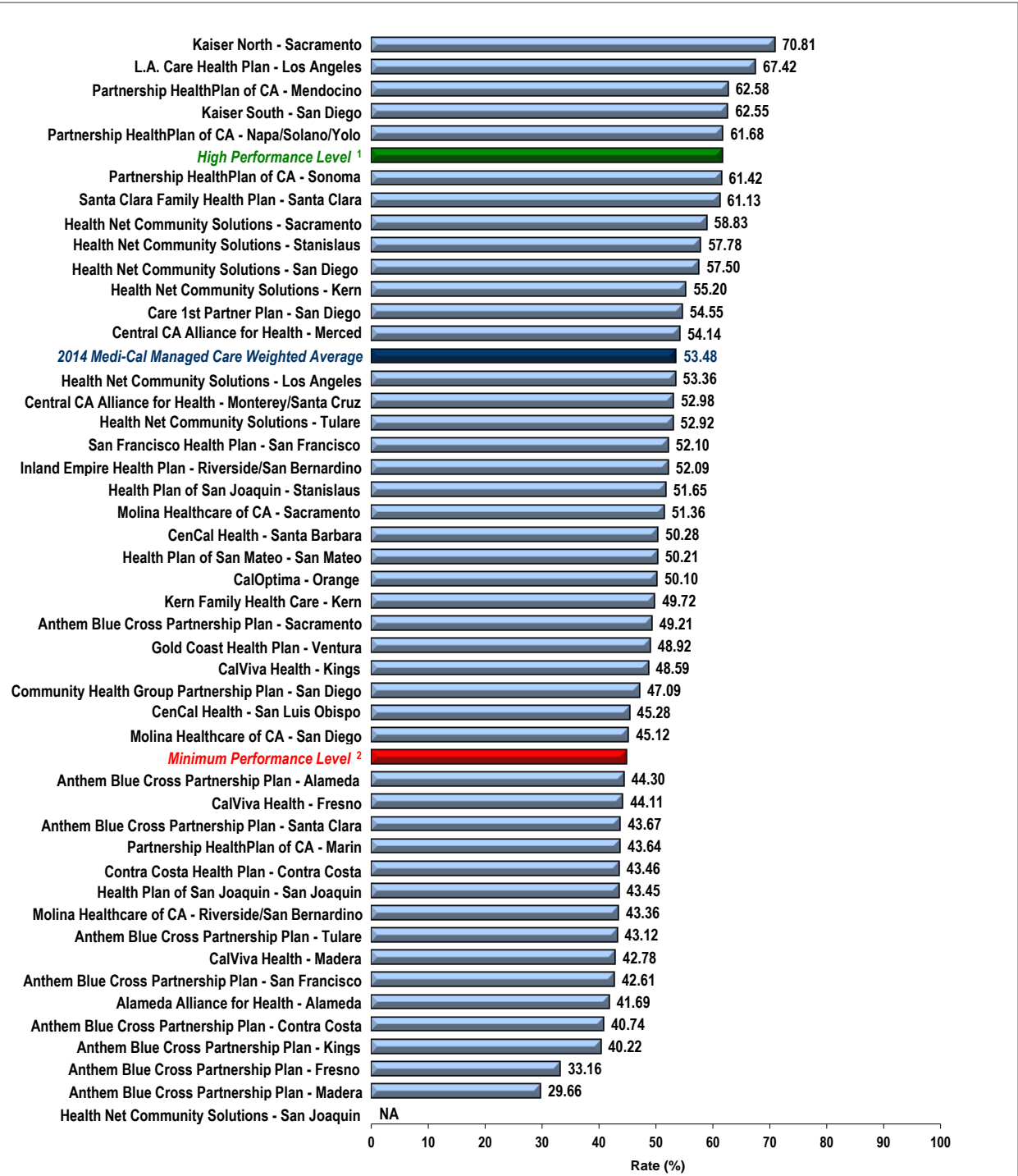
Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care

HEDIS 2014 Medication Management for People with Asthma—Medication Compliance 50% (Total)



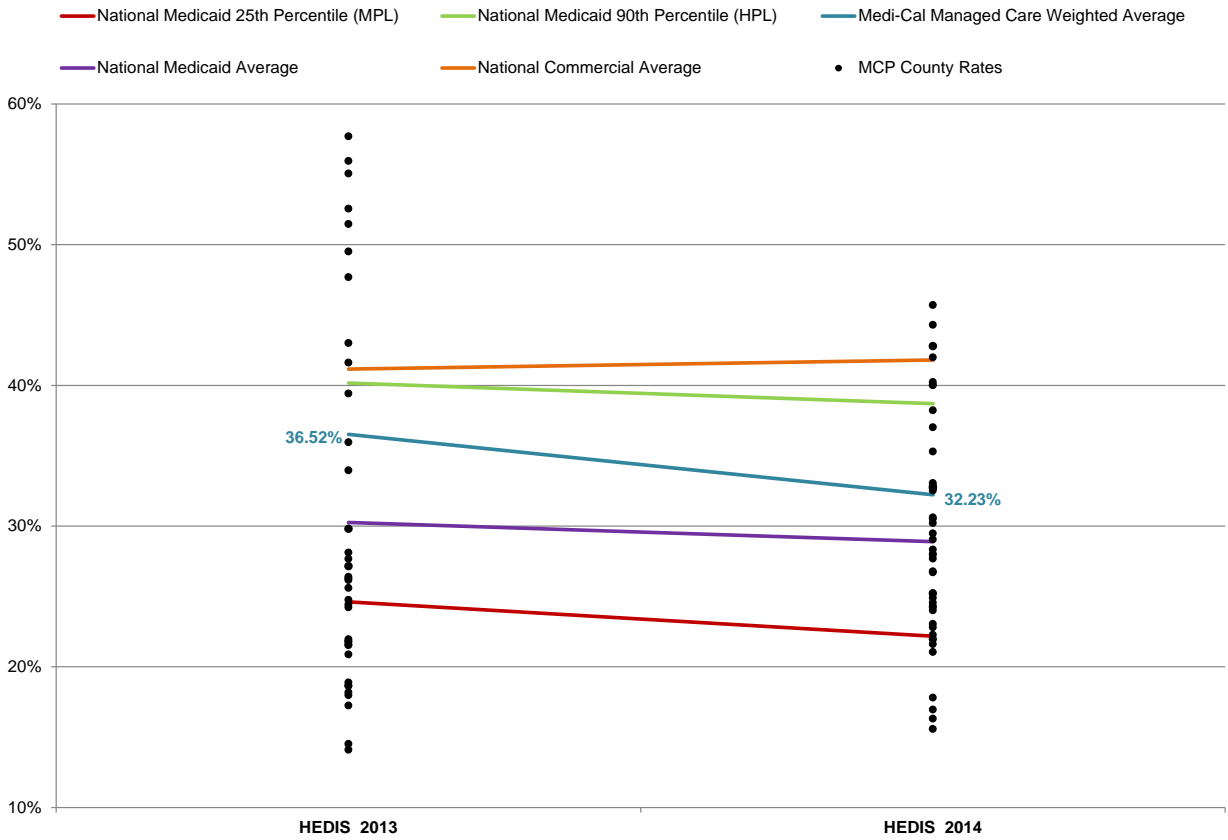
¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

NA = A Not Applicable audit finding because the MCP's denominator was too small (i.e., less than 30).

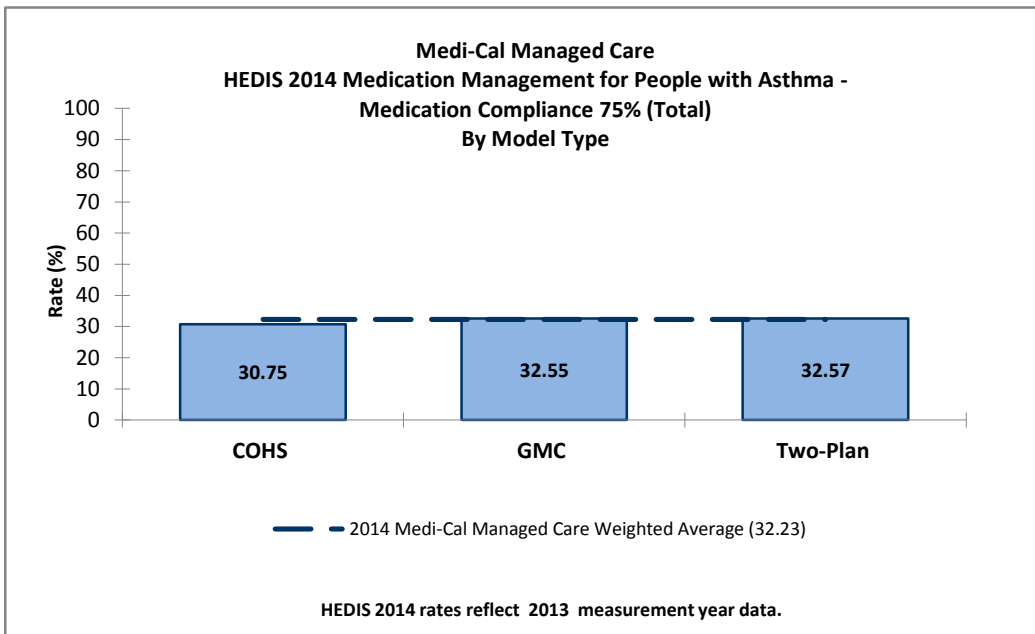
Note: HEDIS 2014 rates reflect 2013 measurement year data.

**Performance Results—Medication Management for People with Asthma—
Medication Compliance 75% (Total)**



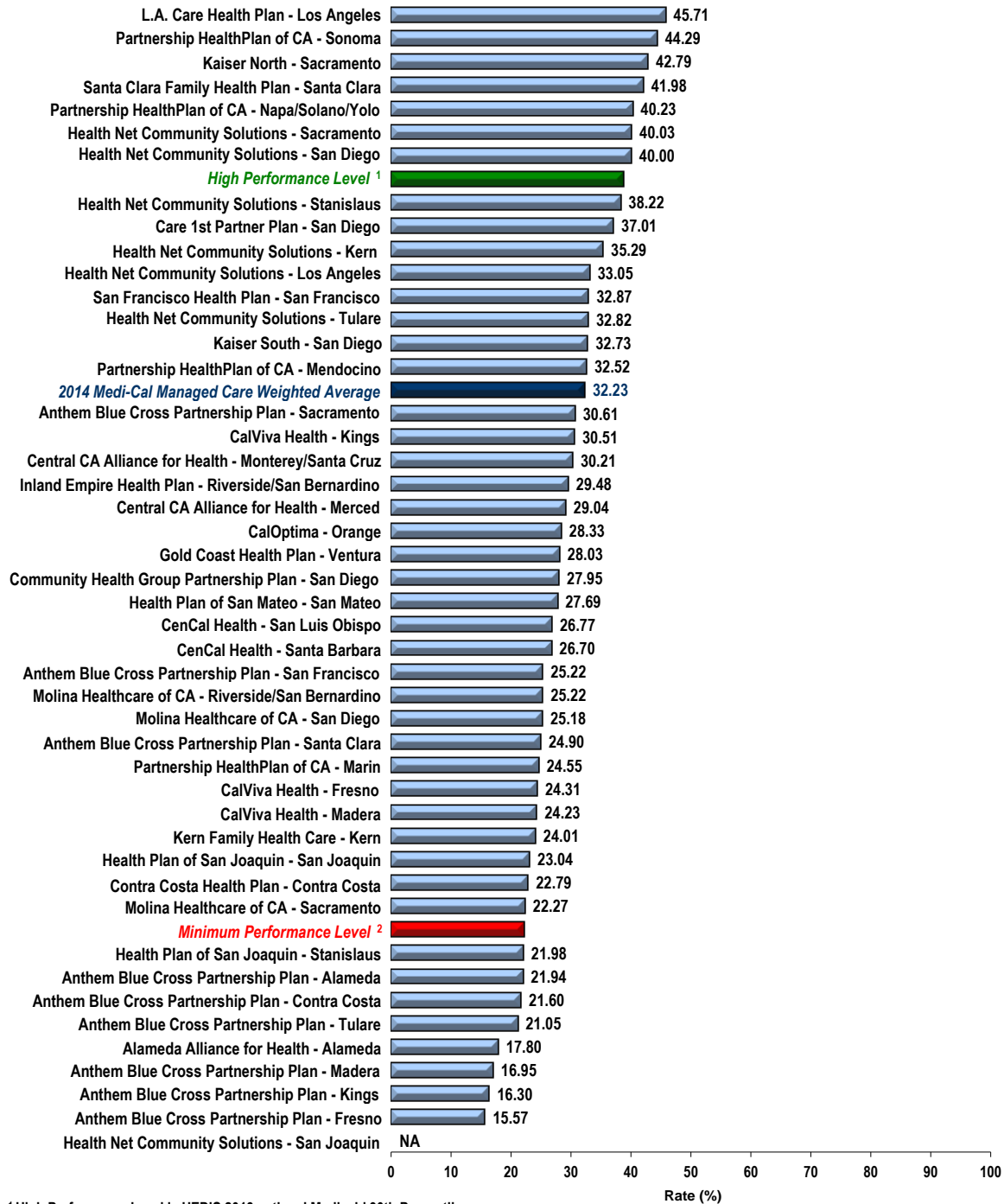
Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care

HEDIS 2014 Medication Management for People with Asthma—Medication Compliance 75% (Total)



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

NA = A Not Applicable audit finding because the MCP's denominator was too small (i.e., less than 30).

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Medication Management for People with Asthma

HEDIS 2014 was the first year DHCS held the MCPs accountable to meet the national Medicaid 25th percentiles (MPLs) for the *Medication Management for People with Asthma* measures since 2013 was the first year the measures were part of DHCS's External Accountability Set (EAS).

The 2014 MCMC weighted averages for the *Medication Compliance 50% (Total)* and *Medication Compliance 75% (Total)* measures were above the MPLs and national Medicaid averages for the measures and below the national Medicaid 90th percentiles (HPLs) and national commercial averages for the measures.

Performance was similar across all three models for the *Medication Compliance 50% (Total)* measure. For the *Medication Compliance 75% (Total)* measure, the TPM and GMC model performed similarly, and outperformed the COHS model by just under 2 percentage points.

High and Low Performers

Medication Compliance 50% (Total)

The rates for five MCP counties were above the HPL, and nine MCP counties had rates with statistically significant improvement from 2013 to 2014. Of the nine MCP counties with significant improvement in their rates, six were able to improve their rates from below the MPL in 2013 to above the MPL in 2014. Although the rate for Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino counties improved significantly, the rate remained below the MPL in 2014. Three MCP county rates with non-statistically significant improvement moved from below the MPL in 2013 to above the MPL in 2014:

- ◆ Anthem Blue Cross Partnership Plan—Sacramento County
- ◆ CenCal Health—San Luis Obispo County
- ◆ Kern Family Health Care—Kern County

The rates for 15 MCP counties were below the MPL in 2014, and the rates for nine MCP counties declined significantly from 2013 to 2014.

Health Net Community Solutions, Inc.—San Joaquin County had an audit result of “NA” for this measure, meaning that although the MCP complied with all applicable specifications, it had a denominator less than 30 for the measure, resulting in the “NA” audit result.

Medication Compliance 75% (Total)

The rates for seven MCP counties were above the HPL, and 11 MCP counties had rates with statistically significant improvement from 2013. Of the 11 MCP counties with significant

improvement in their rates, seven were able to improve their rates from below the MPL in 2013 to above the MPL in 2014. Three MCP county rates with non-statistically significant improvement moved from below the MPL in 2013 to above the MPL in 2014:

- ◆ Anthem Blue Cross Partnership Plan—San Francisco County
- ◆ Kern Family Health Care—Kern County
- ◆ Molina Healthcare of California Partner Plan, Inc.—Sacramento County

The rates for eight MCP counties were below the MPL in 2014, and the rates for 10 MCP counties declined significantly from 2013 to 2014. (Note: The rate for Health Plan of San Joaquin—Stanislaus County was one of the eight rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL).

Health Net Community Solutions, Inc.—San Joaquin County had an audit result of “NA” for this measure, meaning that although the MCP complied with all applicable specifications, it had a denominator less than 30 for the measure, resulting in the “NA” audit result.

Best and Emerging Practices—Medication Management for People with Asthma

MHPA’s *Childhood Asthma Care Best Practices Compendium* provides examples of initiatives being implemented by health plans to improve the care being provided to members with asthma. Following are examples of two initiatives targeting members with asthma that include efforts to increase appropriate treatment for asthma and improve adherence to asthma medication.⁸⁵

HealthCare USA, a Coventry Health Care Plan

HealthCare USA implemented a patient-centered asthma disease management program in Missouri for adults and pediatric members with asthma to reduce asthma-related morbidity and negative lifestyle impact. The program includes multiple initiatives, including:

- ◆ Early identification of and outreach to members with asthma.
- ◆ Education on environmental triggers.
- ◆ Efforts to reduce emergency room visits.
- ◆ Review of medication refill history.
- ◆ Member and provider incentive programs.

⁸⁵ Medicaid Health Plans of America: Centers for Best Practices. *Childhood Asthma Care Best Practices Compendium*. 2011. Available at: <http://www.mhpa.org/upload/Asthma%20CompendiumFINAL.pdf>. Accessed on: August 14, 2014.

From June 2007 to August 2010, the health plan saw an increase in adherence to asthma medications—from a baseline of 17 percent to 30 percent. As a result of the improved medication adherence, asthma-related emergency room visit rates were lower for members enrolled in the disease management program when compared to members not enrolled in the program.

WellCare

In 2010, WellCare Health Plans, Inc., developed initiatives for its health plans, providers, and members to enhance the overall quality and effectiveness of asthma care. One aspect of the initiative in Georgia was to target and reduce disparities in access to care, which were resulting in higher use of emergency department visits by non-Hispanic Blacks than by other members. The initiative involved redesigning member fulfillment materials and educational mailings with culturally appropriate messaging. Additionally, the case management nurses, who managed Georgia's members, were given priority for cultural competency training.

WellCare's pharmacy department developed a pilot program to notify PCPs of gaps in asthma care. Pharmacy claims for excessive use of short-acting beta-agonist rescue inhalers are identified and alert letters are sent to the prescribing providers. The letters include member-specific claims information along with a recommendation to add maintenance inhaled corticosteroid therapy, increase the dose of inhaled corticosteroids, or add a long-acting beta-agonist, as appropriate, for better symptomatic control.

WellCare's member initiative focuses on improving care coordination and community outreach to high-risk members with asthma. The outreach focuses on members with increased emergency department visits, overutilization of short-acting rescue medications, or documented noncompliance or missing claims data for inhaled corticosteroids for persistent asthma. The community outreach initiative includes telephonic assessments and education, home visits with environmental survey, and care coordination to support appointment scheduling and reminders.

The pharmacy-driven provider notification pilot program resulted in 99 of 648 Medicaid members who had overutilized short-acting beta-agonists being prescribed maintenance inhaled corticosteroids. Additionally, the initiative resulted in a 46.4 percent decrease in use of short-acting medications for 262 of 565 Medicaid members who were previously on an inhaled corticosteroid and had also overutilized a short-acting beta-agonist.

Prenatal and Postpartum Care—Postpartum Care

Measure Definition

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

Importance

Postpartum care is an important determinant of quality health care outcomes for women giving birth. Since medical complications can occur after a woman has given birth, postpartum visits can address any adverse effects that giving birth had on a woman's body, such as persistent bleeding, inadequate iron levels, elevated blood pressure, pain, emotional changes, and infections. For example, heavy bleeding can be an indicator of a retained placenta, uterine atony, lacerations, hematoma, or coagulation disorders. However, socioeconomic factors that present barriers to consistent care are common in the Medicaid population. In 2010, almost 81 percent of members enrolled in commercial health plans received timely postpartum care; however, only 64 percent of Medicaid members received timely postpartum care.⁸⁶

Postpartum depression is one of the most prevalent complications that can occur after delivery. Approximately 85 percent of women experience some form of mood changes during the postpartum phase. An estimated 10 to 15 percent of these women suffer from a more persistent form of depression, while 0.1 to 0.2 percent of women have postpartum psychosis. Untreated postpartum depression can lead to long-term effects on the mother-child relationship and the child's development and behavior.⁸⁷ Receiving appropriate postpartum care can address these emotional issues.

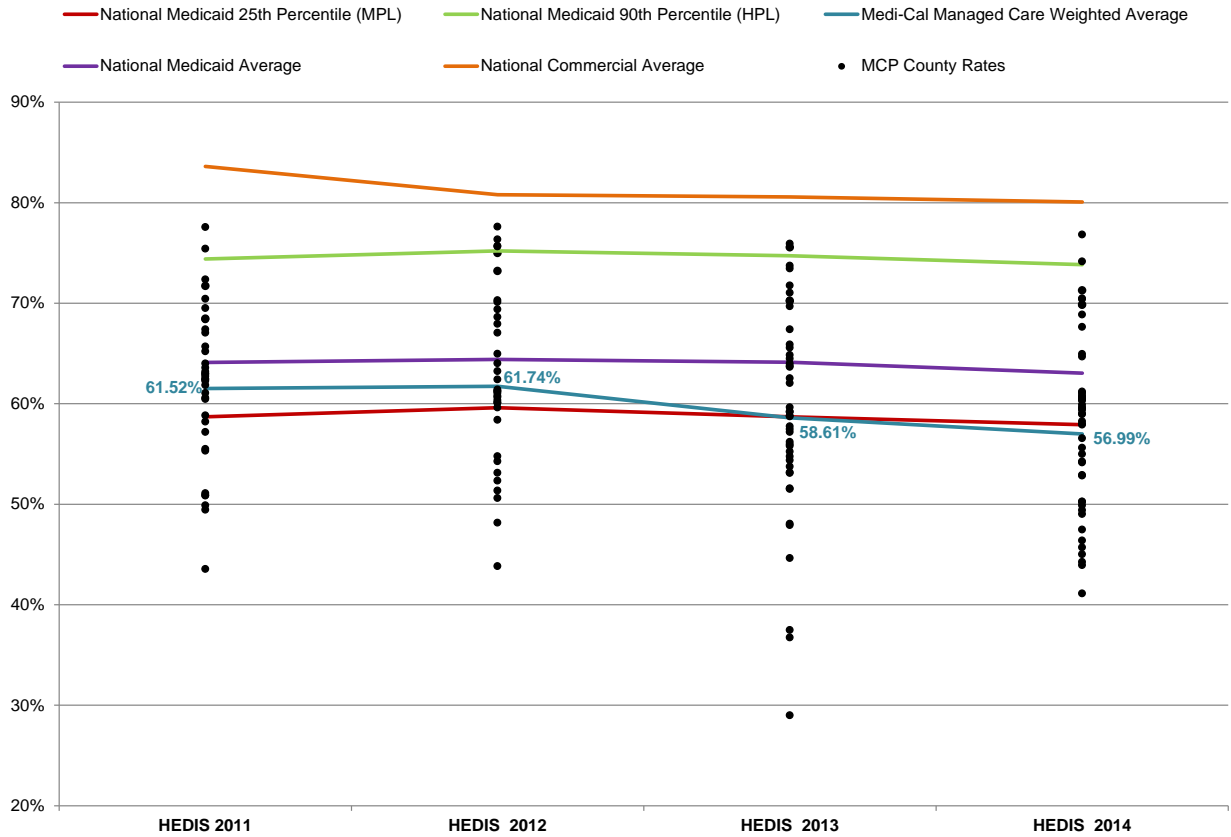
In addition to emotional issues, there are physical issues associated with pregnancy that should be closely monitored during the postpartum period. The most common issues include postpartum infections in the uterus, bladder, or kidney; excessive bleeding; perineal area pain; vaginal discharge; breast pain including swollen breasts, infection, and clogged ducts; hemorrhoids, constipation; and hair loss.⁸⁸ Women can be treated for these issues during the postpartum period. Postpartum visits also provide an opportunity for women to be instructed on certain health care guidelines, such as contraceptive use.

⁸⁶ Women's Health USA 2012. *Quality of Women's Health Care*. Available at <http://www.mchb.hrsa.gov/whusa12/hsu/pages/qwhc.html>. Accessed on: June 7, 2014.

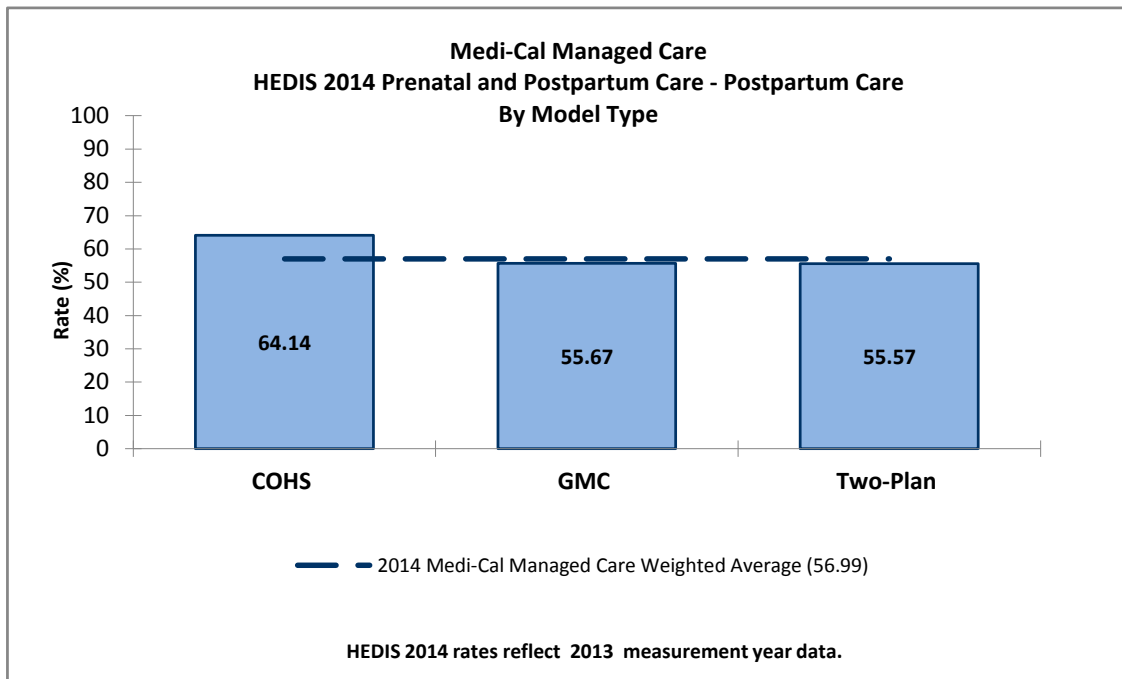
⁸⁷ Medscape. *Postpartum Depression*. Updated April 17, 2014. Available at: <http://reference.medscape.com/article/271662-overview>. Accessed on June 30, 2014.

⁸⁸ MedicineNet.com. *Postpartum Problems*. Available at <http://www.medicinenet.com/script/main/art.asp?articlekey=51744>. Accessed on July 7, 2014.

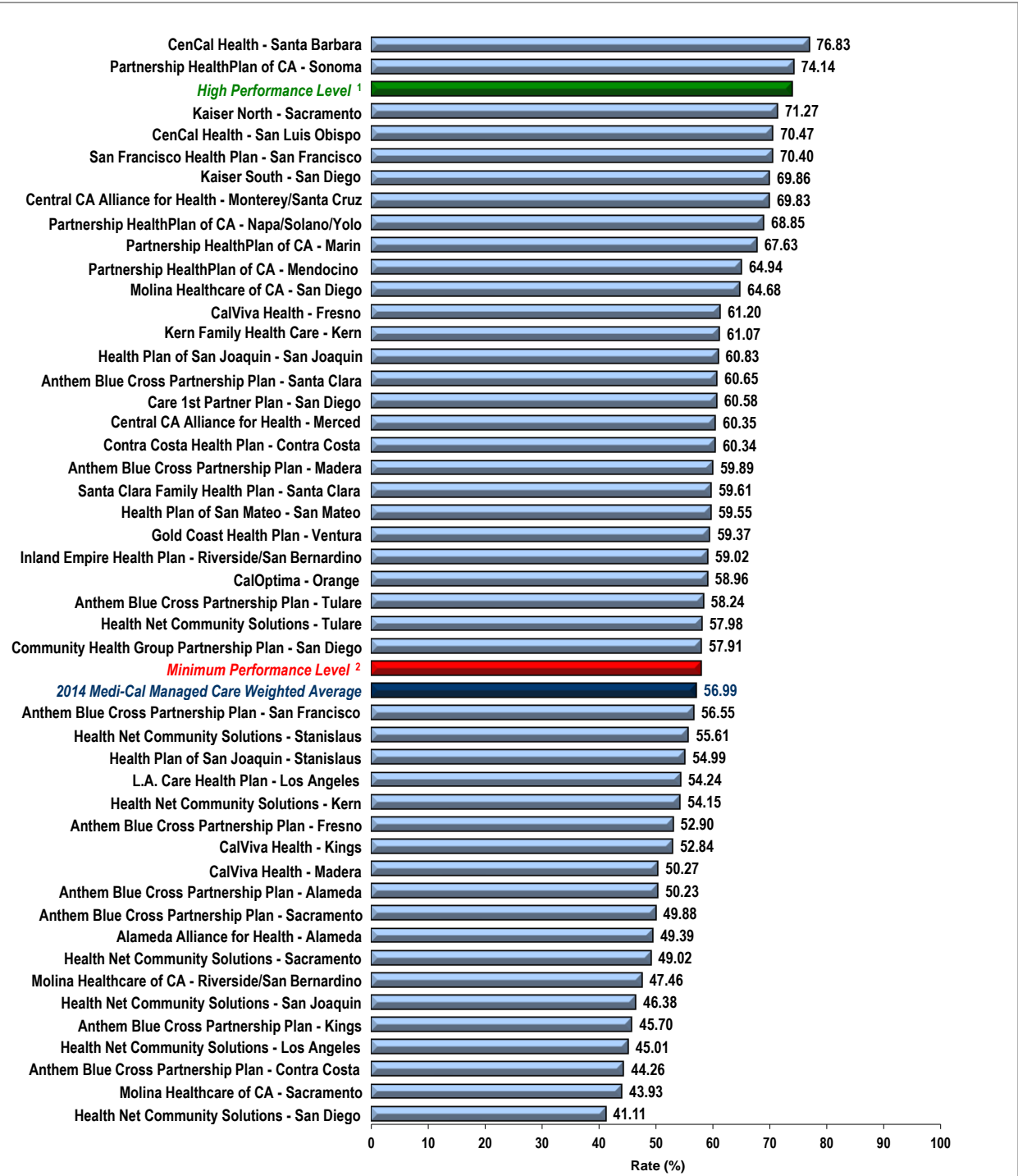
Performance Results—Prenatal and Postpartum Care—Postpartum Care



Note:
 ♦ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
 ♦ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
 ♦ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Prenatal and Postpartum Care—Postpartum Care



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.
² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.
 Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Prenatal and Postpartum Care—Postpartum Care

For the second consecutive year, the MCMC weighted average for the *Prenatal and Postpartum Care—Postpartum Care* measure was below the national Medicaid 25th percentile (MPL). The rate was below the national Medicaid average and national commercial average for the fourth consecutive year. The COHS model outperformed the TPM and GMC model for the fourth consecutive year.

High and Low Performers

The rates for CenCal Health—Santa Barbara County and Partnership HealthPlan of California—Sonoma County were above the national Medicaid 90th percentile (HPL) in 2014. The rates for six MCP counties improved from below the MPL in 2013 to above the MPL in 2014. The rates for four MCP counties improved significantly from 2013 to 2014; however, three of the rates remained below the MPL for the fourth consecutive year:

- ◆ Anthem Blue Cross Partnership Plan—Alameda County
- ◆ Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino counties and Sacramento County

The rates for 19 MCP counties were below the MPL in 2014, and the rates for six MCP counties declined significantly from 2013 to 2014. In addition to the MCPs identified above with rates below the MPL for consecutive years, the following MCP counties had rates below the MPLs for three or more consecutive years:

- ◆ Anthem Blue Cross Partnership Plan—Contra Costa County and Sacramento County—four consecutive years
- ◆ Health Net Community Solutions, Inc.—Los Angeles County—four consecutive years
- ◆ Health Net Community Solutions, Inc.—San Diego County—three consecutive years

The following MCP counties had rates that moved from above the MPL in 2013 to below the MPL in 2014:

- ◆ Anthem Blue Cross Partnership Plan—San Francisco County
- ◆ CalViva Health—Madera County (Note: 2013 was the first year CalViva Health reported a rate for Madera County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).
- ◆ Health Net Community Solutions, Inc.—Stanislaus County

Note: The rates for Health Net Community Solutions, Inc.—San Joaquin County and Health Plan San Joaquin—Stanislaus County were two of the 19 rates below the MPL in 2014; however, 2014

was the first year the MCPs reported rates for this measure for these counties and DHCS therefore did not hold the MCPs accountable to meet the MPL.

Best and Emerging Practices—Prenatal and Postpartum Care—Postpartum Care

MHPA's Center for Best Practices provides information on best practices in the clinical and operations areas of Medicaid health plans. Following are three examples of efforts that resulted in improvements in the timeliness of postpartum care.⁸⁹

CareNet Southern Health Services, Inc., a Coventry Health Care Plan

CareNet enhanced its perinatal program in 2008 to better identify at-risk mothers. The plan developed more comprehensive initiatives to improve outreach to at-risk mothers and in 2010, added a neonatal intensive care unit component and increased case management and social worker face-to-face visits to members. The elements of the postpartum program include:

- ◆ Educational mailings to members.
- ◆ Communications to providers.
- ◆ Transportation services.
- ◆ Home visits.
- ◆ Member incentives for making and keeping the postpartum appointment.
- ◆ High-risk OB case management.
- ◆ Postpartum telephone calls.
- ◆ Postpartum depression information and assessments.
- ◆ Wraparound mental health services.

CareNet's *Postpartum Care* rate improved significantly from 2009 to 2011, and the rate moved from the national Medicaid 10th percentile to the 75th percentile, which the plan attributes to the positive effects of the comprehensive perinatal program.

MDwise, Inc.

As described in the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure section, MDwise, Inc.'s Bluebelle Beginnings program aims to assist MDwise members who are pregnant to have a healthy pregnancy and ultimately a healthy baby. As indicated in the *Timeliness of Prenatal*

⁸⁹ Medicaid Health Plans of America: Centers for Best Practices. *2012–2013 Best Practices Compendium*. Available at: <https://www.mhpa.org/upload/2012Compendium.pdf> Accessed on: July 18, 2014

Care measure section, in addition to improvements in the prenatal care score, the program's efforts resulted in an improvement in the postpartum care score.

Amerigroup Maryland

Beginning in 2010, Amerigroup Maryland made changes to its service delivery for pregnant members with a focus on postpartum care. The initiative consisted of several interventions, including case management, prenatal assessments, mailings, outbound calls, appointment coordination, and incentives for members and providers to schedule and keep the postpartum care appointment within 56 days following delivery. The combined interventions resulted in Amerigroup achieving a 3.9 percentage point improvement in its HEDIS postpartum visit rate from 2010 to 2012.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

Measure Definition

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

Importance

Effective prenatal care aids in the identification of high-risk pregnancies and provides educational opportunities to prevent subsequent poor birth outcomes. According to the National Committee for Quality Assurance, the United States spent more than \$26 billion on preterm births in 2011. Timely and frequent prenatal care visits allow health problems to be detected early such as preeclampsia, ectopic pregnancy, gestational diabetes, and hypertension.⁹⁰ A lack of timely prenatal care may indicate weak therapeutic alliances, lack of peer support, hesitation regarding health plans, and residential instability throughout the gestational period. Studies reveal that women in the U.S. who are at risk for inadequate prenatal care are more likely to be non-Caucasian, not a high school graduate, enrolled in Medicaid, unmarried, a smoker, a drug user, and under 20 years of age.⁹¹ Socioeconomic status is a determinant of health outcomes, including poor birth outcomes.⁹² Socioeconomic factors that present barriers to consistent care are common in the Medicaid populations. Due to this lack of care, poor birth outcomes are particularly high among these populations.⁹³ Studies revealed that receiving timely prenatal care is associated with the timing of Medicaid coverage.⁹⁴ In 2008, only 82 percent of Medicaid members received timely prenatal care, compared to approximately 92 percent for members in commercial plans.⁹⁵

⁹⁰ National Committee for Quality Assurance. *The State of Health Care Quality 2013*. Washington DC: NCQA, 2013.

⁹¹ Tough, S., Siever, J., Johnson, D. “Retaining Women in a Prenatal care Randomized Controlled Trial in Canada: Implications for Program Planning.” *BMC Public Health* 2007, 7: 148.

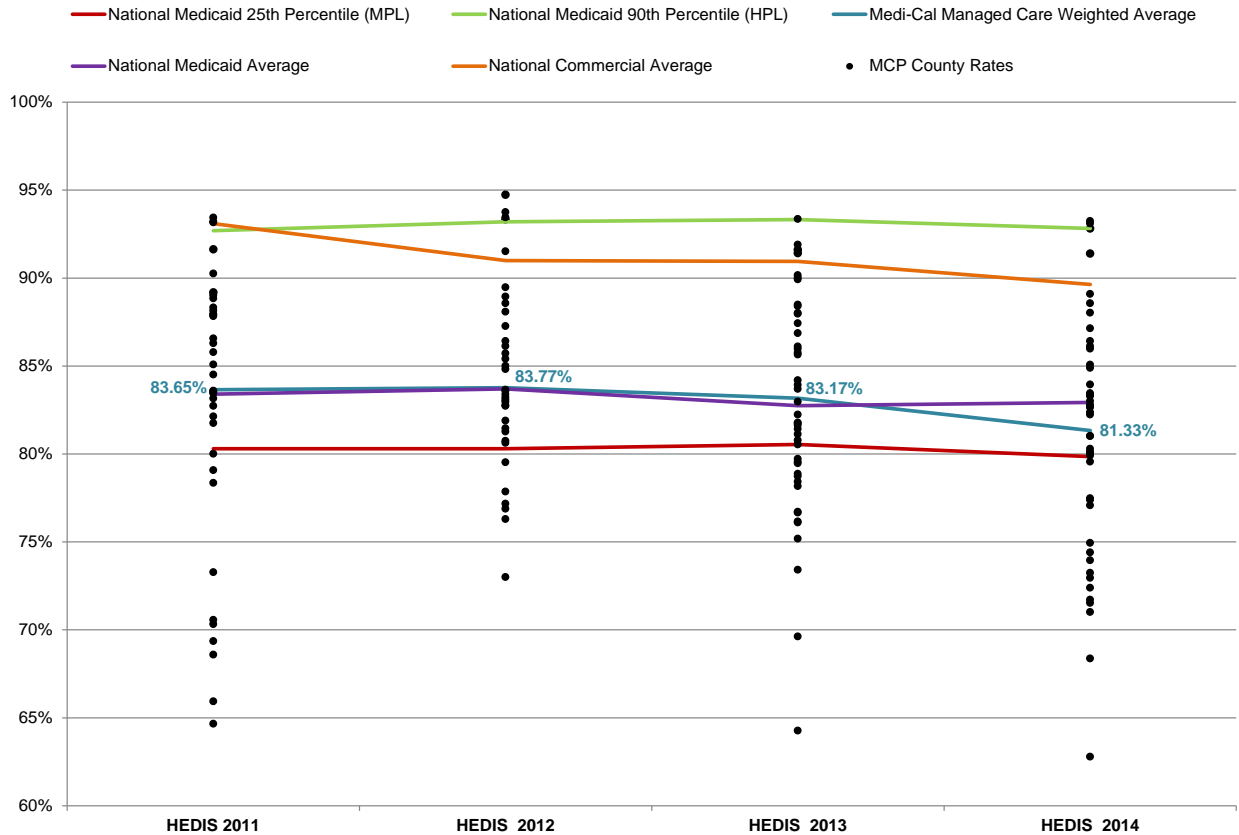
⁹² Zeka, Ariana, Melly, Steve, Schwartz. “The Effects of Socioeconomic Status and Indices of Physical Environment on Reduced Birth Weight and Preterm Births in Eastern Massachusetts.”

⁹³ Shulman, Shanna. “Poor Preventive Care Achievement and Program Retention Among Low Birth Weight Infant Medicaid Enrollees.” *Pediatrics*. Nov 2006. 118(5): e1509-e1515. Available at: <http://pediatrics.aappublications.org/cgi/reprint/118/5/e1509> Accessed on: September 11, 2013.

⁹⁴ Gavin, N., Adams, K., Manning, W., et al. 2007 August. “The Impact of Welfare Reform on Insurance Coverage before Pregnancy and the Timing of Prenatal Care Initiation.” *Health Services Research* 42(4): 1564–1588.

⁹⁵ National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington DC: NCQA, 2009.

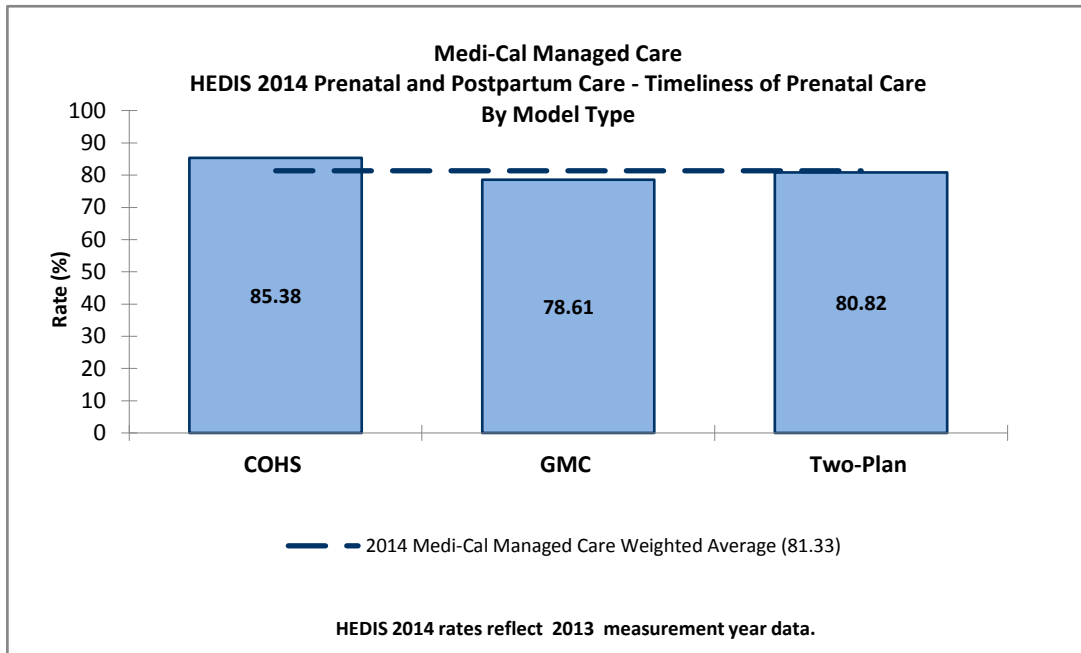
Performance Results—Prenatal and Postpartum Care—Timeliness of Prenatal Care



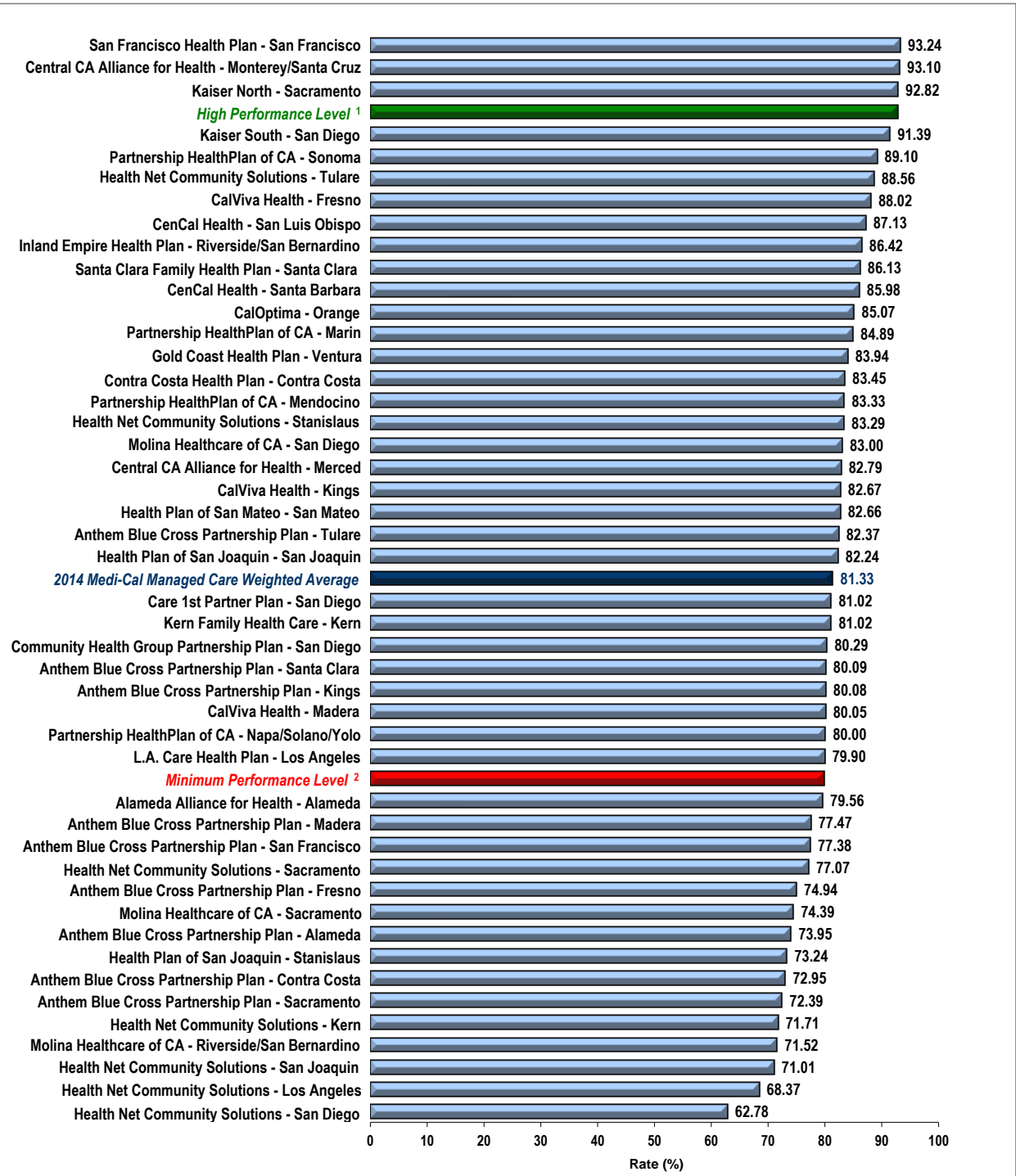
Healthy People 2020 Goal: 77.90%

Note:

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- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Prenatal and Postpartum Care—Timeliness of Prenatal Care



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.
² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.
 Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Prenatal and Postpartum Care—Timeliness of Prenatal Care

The MCMC weighted average for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure declined by just under 2 percentage points from 2013 to 2014; however, the rate remained above the national Medicaid 25th percentile (MPL) for the fourth consecutive year. The decline in the rate from 2013 to 2014 resulted in the rate falling below the national Medicaid average. Additionally, for the fourth consecutive year, the MCMC weighted average was below the national commercial average. The COHS model outperformed the TPM and GMC model.

High and Low Performers

The rates for the following MCP counties were above the national Medicaid 90th percentile (HPL) in 2014:

- ◆ Central California Alliance for Health—Monterey/Santa Cruz counties
- ◆ Kaiser North—Sacramento County
- ◆ San Francisco Health Plan—San Francisco County

The rates for the following MCP counties improved from 2013 to 2014, and although the improvement was not statistically significant, the change resulted in the rates moving from below the MPL in 2013 to above the MPL in 2014:

- ◆ Anthem Blue Cross Partnership Plan—Santa Clara County
- ◆ Molina Healthcare of California Partner Plan, Inc.—San Diego County
- ◆ Partnership HealthPlan of California—Marin County

The rates for five MCP counties improved significantly from 2013 to 2014, and the improvement for two of the MCP counties resulted in the rates moving from below the MPL in 2013 to above the MPL in 2014:

- ◆ Anthem Blue Cross Partnership Plan—Tulare County
- ◆ CalOptima—Orange County

Although the rate for Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino counties improved significantly from 2013, the rate remained below the MPL for the fourth consecutive year.

The rates for 15 MCP counties were below the MPL in 2014, with the rates for three of Anthem Blue Cross Partnership Plan's counties—Alameda, Contra Costa, and Sacramento—below the MPL for the fourth consecutive year. The rates for eight MCP counties declined significantly from

2013 to 2014, and the decline for Anthem Blue Cross Partnership Plan—San Francisco County resulted in the rate moving from above the MPL in 2013 to below the MPL in 2014.

The rates for the following MCP counties declined from 2013 to 2014, and although the decline was not statistically significant, the change resulted in the rates moving from above the MPL in 2013 to below the MPL in 2014:

- ◆ Alameda Alliance for Health—Alameda County
- ◆ Health Net Community Solutions, Inc.—Sacramento County

Note: The rates for Health Net Community Solutions, Inc.—San Joaquin County and Health Plan San Joaquin—Stanislaus County were two of the 15 rates below the MPL in 2014; however, 2014 was the first year the MCPs reported rates for this measure for these counties and DHCS therefore did not hold the MCPs accountable to meet the MPL.

Best and Emerging Practices—Prenatal and Postpartum Care—Timeliness of Prenatal Care

MHPA's Center for Best Practices provides information on best practices in the clinical and operations areas of Medicaid health plans. Following are three examples of efforts that resulted in improvements in the timeliness of prenatal care.⁹⁶

AmeriHealth Mercy Health Plan and Keystone Mercy Health Plan

AmeriHealth Mercy Health Plan and Keystone Mercy Health Plan developed and implemented a pregnancy identification algorithm to facilitate early identification of pregnant members. The early identification of pregnant members is performed by data mining of medical, behavioral health, pharmacy claims, and Logical Observation Identifiers Names and Codes utilization; new member assessments and obstetrical needs assessment form; provider referrals; member requests; and health plan activity. The health plans prepare a weekly report to send to their maternity teams that identifies members requiring outreach and follow-up. A care manager contacts the members to enroll them in maternity care management and completes a risk assessment. Members assessed as low-risk receive information via mail, care reminders, and on-demand access to a care manager. Members identified as having a medium- or high-risk pregnancy are aggressively managed by the health plan, with a team of care managers and care connectors through the plans' Integrated Care Management Program. Both health plans saw improvement in their *Frequency of Ongoing Prenatal Care* and *Timeliness of Prenatal Care* measures from 2010 to 2011, with the improvement for

⁹⁶ Medicaid Health Plans of America: Centers for Best Practices. *2012–2013 Best Practices Compendium*. Available at: <https://www.mhpa.org/upload/2012Compendium.pdf>. Accessed on: July 18, 2014.

Keystone Mercy Health Plan's *Frequency of Ongoing Prenatal Care* measure being statistically significant.

United Healthcare Community & State

As described in the *Children and Adolescents' Access to Primary Care Practitioners* measure section, United Healthcare Community & State's Baby Blocks program engages expectant and new mothers with a mobile-optimized game board that reminds them of upcoming prenatal, postpartum, and well-child appointments through 15 months of age. Also as indicated in the *Children and Adolescents' Access to Primary Care Practitioners* measure section, the pilot phase showed promising results, and at the time of the report, the program had the potential to reach nearly 50,000 pregnant women.

MDwise, Inc.

MDwise, Inc.'s Bluebelle Beginnings program aims to assist MDwise members who are pregnant to have a healthy pregnancy and ultimately a healthy baby. The program involves multiple initiatives, including Bluebelle Baby Showers, which focus on providing expectant and new moms with the information they need to provide healthier outcomes for themselves and their babies. In addition to holding the baby showers, program initiatives include:

- ◆ Mailing a prenatal booklet to pregnant members as soon as the plan is aware of the pregnancy through the claims process.
- ◆ Distributing an educational brochure throughout provider offices that highlights the importance of prenatal care throughout a pregnancy and describes how members can accumulate points through the MDwise Rewards program.
- ◆ Shortly after sending the prenatal booklet, sending a direct mail postcard to pregnant members highlighting prenatal care.
- ◆ Once per year, mailing all pregnant members a letter with a link to online pregnancy educational materials.
- ◆ Once per year, making agentless calls to pregnant members about the importance of prenatal doctor visits.
- ◆ Case managers calling high-risk members.
- ◆ Promoting the Text4baby program on the MDwise website and in outreach and educational materials. The Text4baby program provides relevant prenatal, postpartum, and parenting information.

The direct mailings and educational materials reach more than 19,000 pregnant MDwise members per year, and the Bluebelle Baby Showers have reached more than 1,400 pregnant women across Indiana. The program has resulted in an improvement in prenatal and postpartum care scores.

Use of Imaging Studies for Low Back Pain

Measure Definition

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

Importance

Low back pain is a common and expensive cause of lost productivity and work days in the United States. According to NCQA, 75 to 85 percent of Americans will, at one point, experience back pain.⁹⁷ Frequently, low back pain is also the cause for patients' calls and visits to a primary care clinician. For most patients, acute low back pain is non-specific. A history and physical examination can provide clues to the rare but potentially serious causes of low back pain. While imaging may be appropriate for patients at risk for more serious conditions, the majority of patients experience low back pain that is non-specific and with no identifiable cause. According to the American College of Radiology, acute low back pain without complications is usually benign and self-limiting, and does not necessitate early imaging studies, such as X-rays, MRIs, or CT scans. Most patients return to their usual activities within a month.

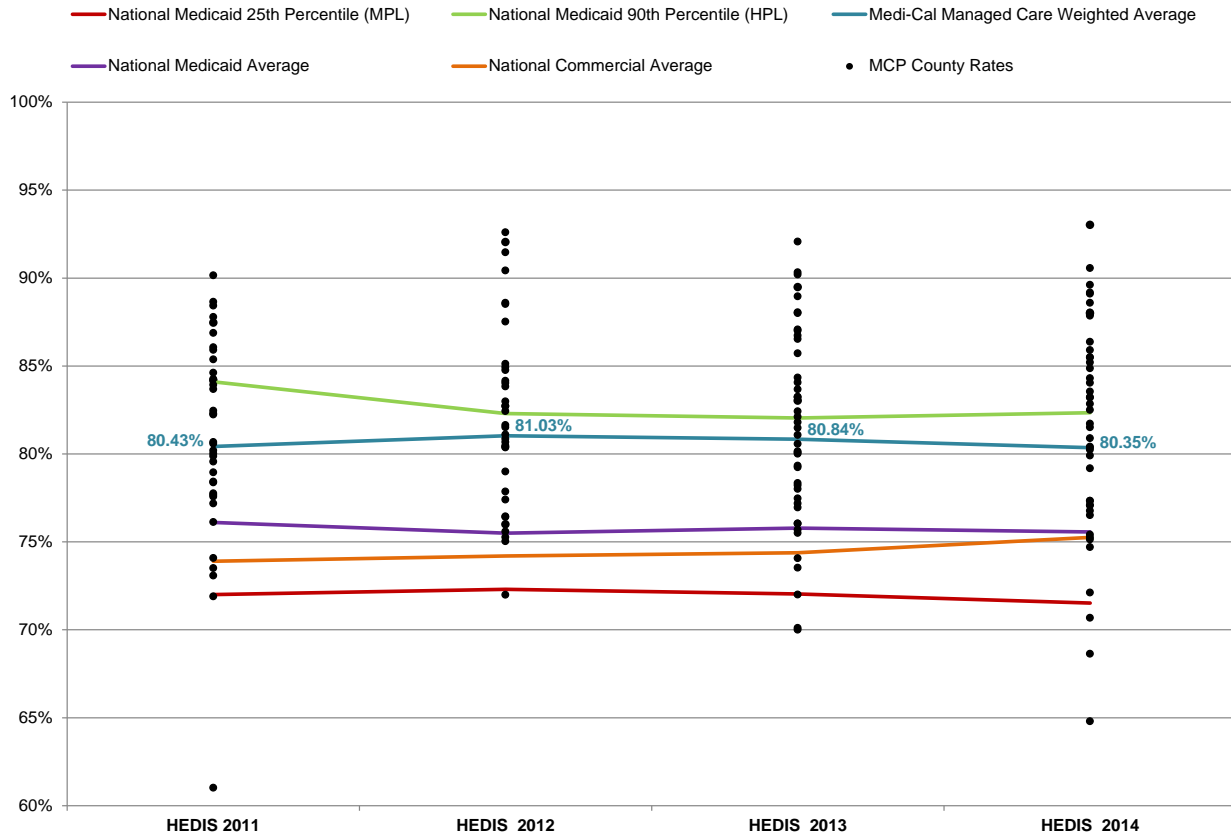
Studies have shown that complications from unnecessary surgery potentially increase the duration of low back pain. In 2008, the Agency for Healthcare Research and Quality (AHRQ) determined 18,000 patients were treated for back pain at a cost of \$35 billion.⁹⁸ Furthermore, despite this evidence, imaging studies are commonly overused in the evaluation of patients with acute low back pain. Less than 1 percent of radiographs find the cause of low back pain.⁹⁹ Abnormalities found when imaging patients with and without back pain had similar prevalence. Other than patient satisfaction, most patients given standard low back care experienced no difference in health outcomes compared to those given lower back radiographs.

⁹⁷ National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington DC: NCQA, 2013.

⁹⁸ Agency for Healthcare Research and Quality. National Quality Measures Clearinghouse. Available at: <http://www.qualitymeasures.ahrq.gov/content.aspx?id=47190&search=low+back+pain>. Accessed on: June 24, 2014.

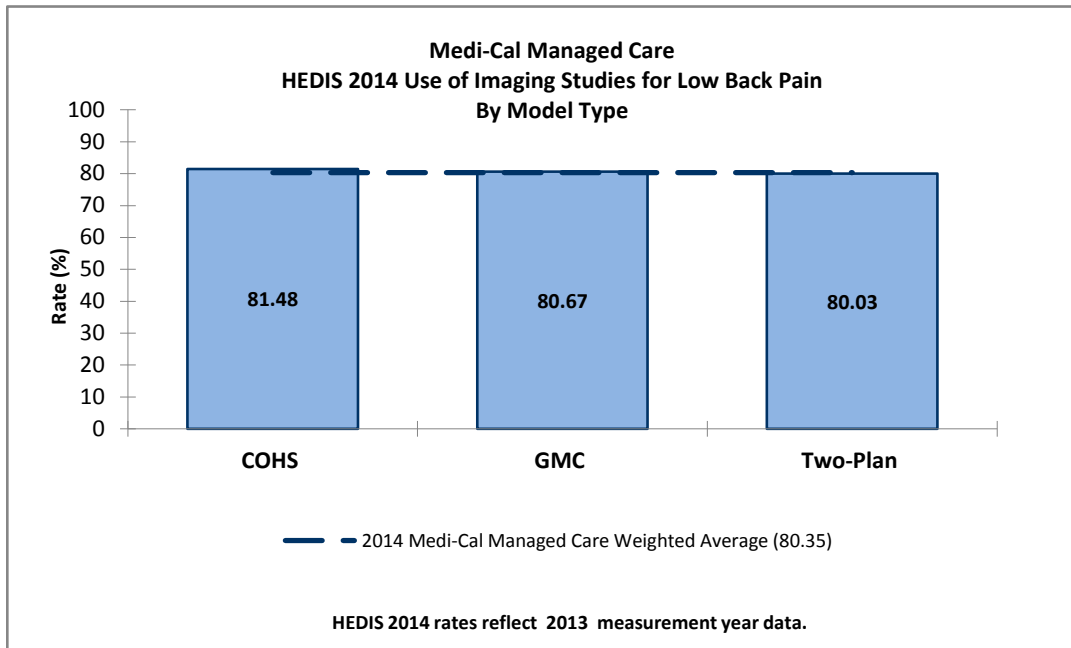
⁹⁹ National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington DC: NCQA, 2013.

Performance Results—Use of Imaging Studies for Low Back Pain

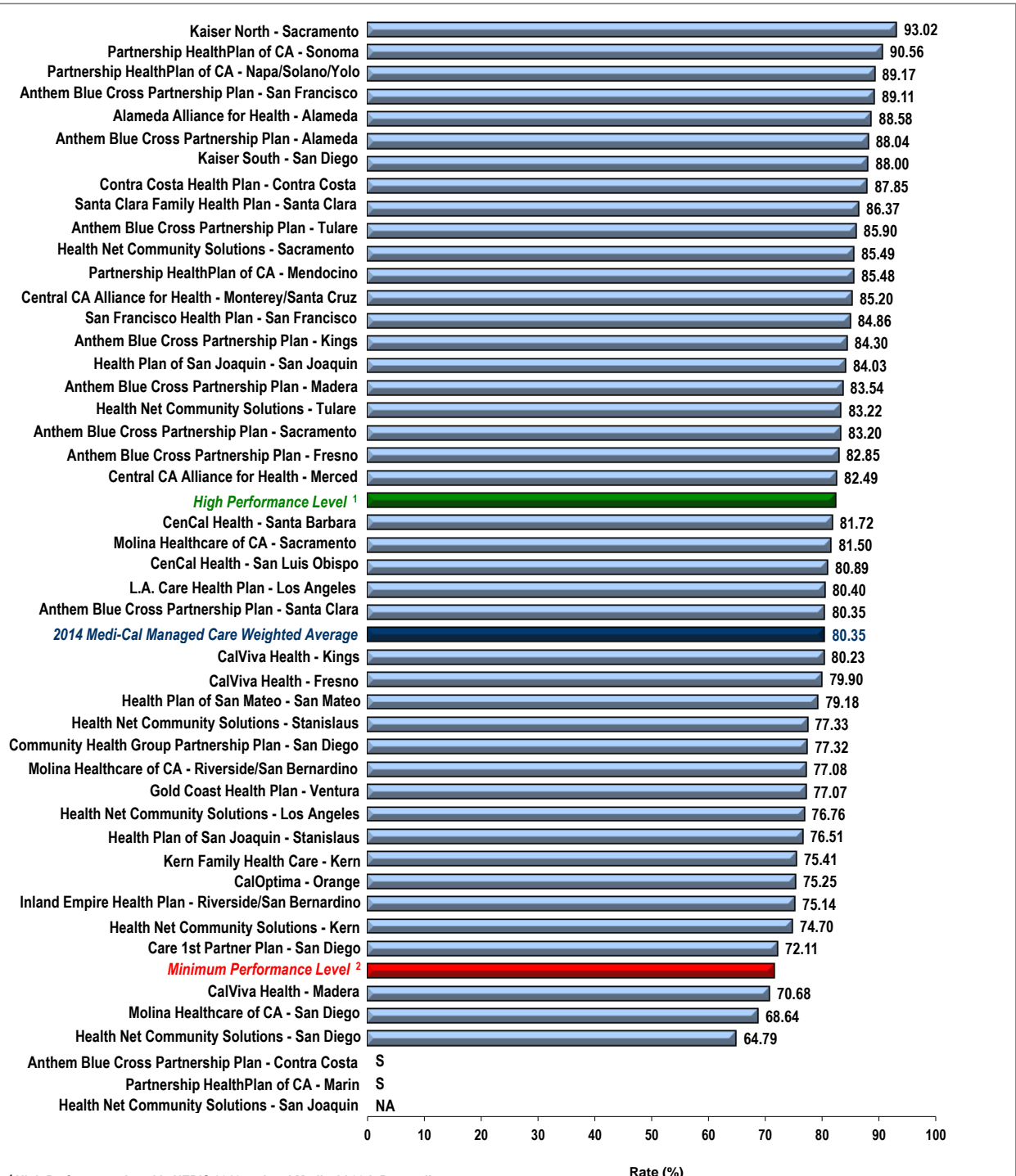


Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Use of Imaging Studies for Low Back Pain



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

NA = A Not Applicable audit finding because the MCP's denominator was too small (i.e., less than 30).

S = The measure is publicly reported based on audit results; however, since the MCP's numerator was less than 11, DHCS suppresses displaying the rate to satisfy the HIPAA Privacy Rule's de-identification standard.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Use of Imaging Studies for Low Back Pain

For the fourth consecutive year, the MCMC weighted average for the *Use of Imaging Studies for Low Back Pain* measure exceeded the national Medicaid 25th percentile (MPL), national Medicaid average, and national commercial average for this measure. The rate remained below the national Medicaid 90th percentile (HPL). The COHS model, GMC model, and TPM performed similarly in 2014.

High and Low Performers

The rates for 23 MCP counties were above the HPL in 2014, with the rates for eight MCP counties above the HPL for the fourth consecutive year and the rates for two MCP counties above the HPL for the third consecutive year. Note that while the rates for Anthem Blue Cross Partnership Plan—Contra Costa County and Partnership HealthPlan of California—Marin County are shown as suppressed in the ranking chart, the rates for both MCP counties were above the HPL.

The rates for the following three MCP counties improved significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—Madera County and Tulare County
- ◆ Santa Clara Family Health Plan—Santa Clara County

The improvement in the rate for Anthem Blue Cross Partnership Plan—Madera County resulted in the rate moving from below the MPL in 2013 to above the HPL in 2014. (Note: 2013 was the first year Anthem Blue Cross Partnership Plan reported a rate for Madera County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

The rate for Care1st Partner Plan—San Diego County improved from 2013 to 2014, and although the improvement was not statistically significant, the change resulted in the rate moving from below the MPL in 2013 to above the MPL in 2014.

The rates for the following MCP counties were below the MPL in 2014:

- ◆ CalViva Health—Madera County
 - The rate declined from 2013 to 2014, and although the decline was not statistically significant, the change resulted in the rate moving from above the MPL in 2013 to below the MPL in 2014. (Note: 2013 was the first year CalViva Health reported a rate for Madera County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

- ◆ Health Net Community Solutions, Inc.—San Diego County
 - The rate declined significantly from 2013 to 2014, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014.
- ◆ Molina Healthcare of California Partner Plan, Inc.—San Diego County
 - The rate was below the MPL for the third consecutive year.

In addition to the rate for Health Net Community Solutions, Inc.—San Diego County declining significantly from 2013 to 2014, the rates for the following MCP counties declined significantly from 2013 to 2014:

- ◆ CalOptima—Orange County
- ◆ Contra Costa Health Plan—Contra Costa County
 - Although the rate for this county declined significantly, the rate remained above the HPL for the fourth consecutive year.
- ◆ Inland Empire Health Plan—Riverside/San Bernardino counties

Health Net Community Solutions, Inc.—San Joaquin County had an audit result of “NA” for this measure, meaning that although the MCP complied with all applicable specifications, it had a denominator less than 30 for the measure, resulting in the “NA” audit result.

Best and Emerging Practices—Use of Imaging Studies for Low Back Pain

Focus on Identifying Red Flag Indicators

During the initial assessment of patients with low back pain, clinical guidelines recommend focusing on obtaining a complete medical history and physical examination.¹⁰⁰ The history and physical examination will generally provide “red flag” indicators to rare but potentially serious causes of low back pain and identify if a patient is at risk for chronic disabling back pain. When these red flag indicators are not present, the patient is considered to have non-specific low back pain. Clinical guidelines recommend that clinicians should be restrictive in referral for imaging in patients with non-specific low back pain. Only in cases with red flag conditions should imaging be indicated.¹⁰¹

¹⁰⁰ Agency for Health Care Quality and Research. “Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society.” 2007. *Annals of Internal Medicine*. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17909209>. Accessed on: August 12, 2014.

¹⁰¹ Ibid.

Patient Education

Information about why an imaging test is not indicated is generally sufficient for most patients.¹⁰² Providing patients with evidence-based information on low back pain, including the natural history of low back pain (i.e., its expected course), advising them to remain active, and providing them with information about effective self-care options and how to prevent future episodes can help ensure the patient's expectations are met.

Alternative Therapy

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

¹⁰² Atlas SJ, Deyo RA. Evaluating and Managing Acute Low Back Pain in the Primary Care Setting. *Journal of General Internal Medicine*. 2001; 16: 120–131.

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

Measure Definition

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

Importance

The emergence of obesity in children and adolescents has been one of the most important developments in pediatrics, and its rapidly increasing prevalence is one of the most challenging dilemmas pediatricians face today in the United States. In 1980, it was estimated that 7 percent of children ages 6 to 11 and 5 percent of adolescents ages 12 to 19 were obese. However, in the past 30 years the prevalence of obesity among children and adolescents has increased sharply to 18 percent and 21 percent respectively. Also of great concern are children who are overweight and at risk for becoming obese. Overweight children and adolescents are more likely to become obese as adults.¹⁰³

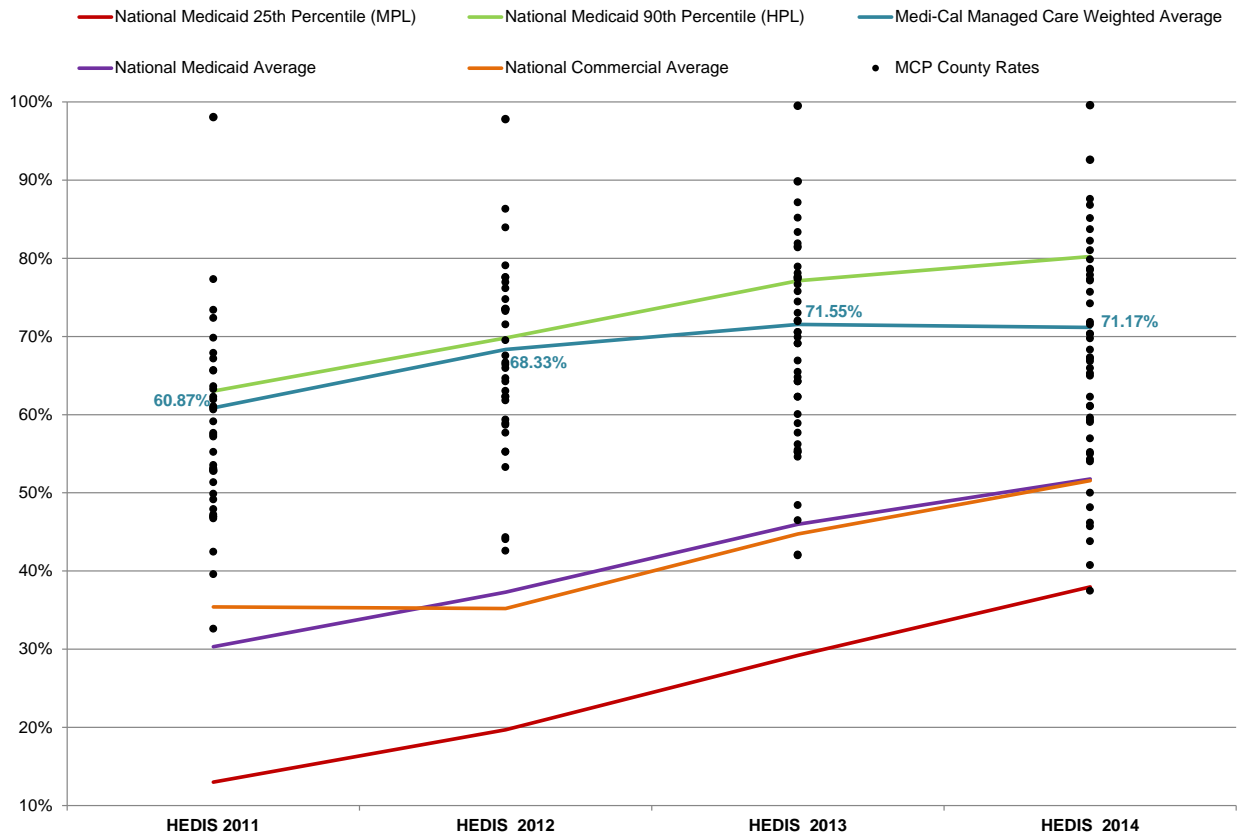
According to NCQA, 23 percent of children ages 9 to 13 do not engage in any free-time physical activity. For young people in grades 9 through 12, the level of physical activity decreases drastically. More than 70 percent of young people in grades 9 through 12 do not meet the recommended levels of physical activity.¹⁰⁴

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

¹⁰³ Centers for Disease Control and Prevention. Adolescent and School Health: Childhood Obesity Facts. Available at: <http://www.cdc.gov/healthyyouth/obesity/facts.htm>. Accessed on: June 17, 2014.

¹⁰⁴ National Committee for Quality Assurance. *The State of Health Care Quality 2013*. Washington DC: NCQA, 2013.

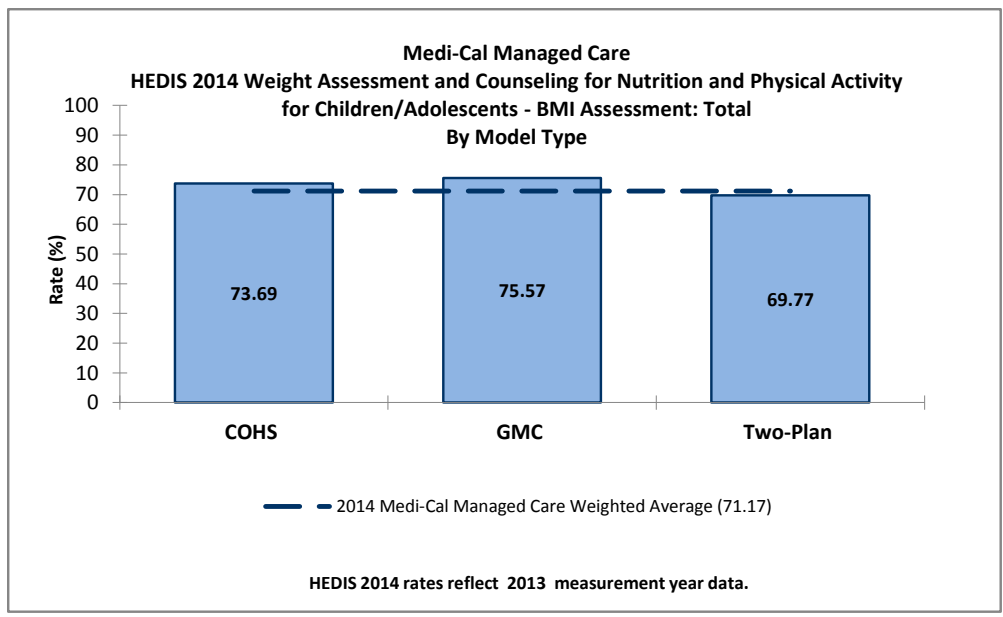
Performance Results—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total



Healthy People 2020 Goal: 54.70%

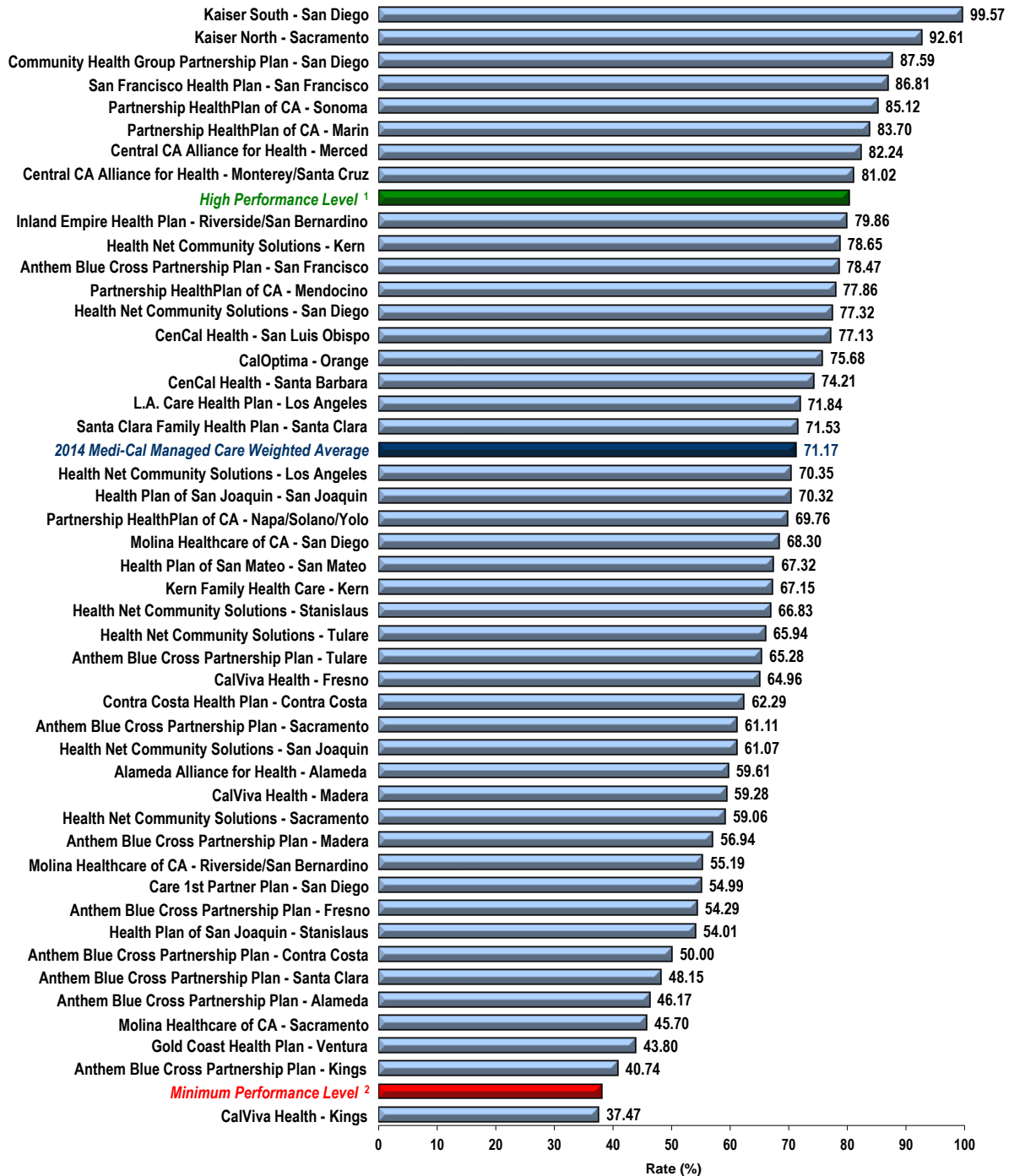
Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



HEDIS 2014 rates reflect 2013 measurement year data.

Medi-Cal Managed Care
 HEDIS 2014 Weight Assessment and Counseling for Nutrition and Physical Activity
 for Children/Adolescents—BMI Assessment: Total



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total

For the fourth consecutive year, the MCMC weighted average for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* measure was higher than the national Medicaid 25th percentile (MPL), national Medicaid and commercial averages, and Healthy People 2020 goal for this measure. The rate remained below the national Medicaid 90th percentile (HPL). The GMC model type performed better than the TPM and COHS model.

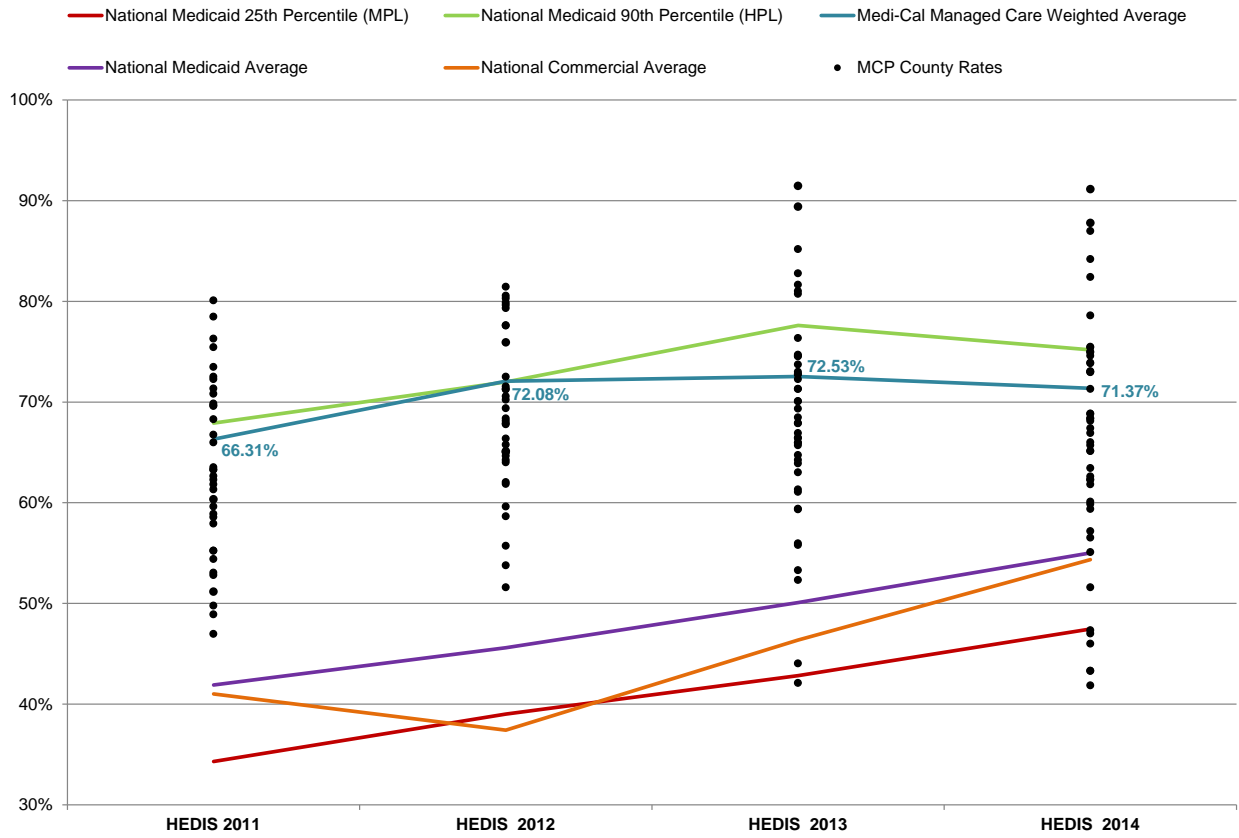
High and Low Performers

The rates for eight MCP counties were above the HPL compared to 14 counties in 2013, and the rates for eight MCP counties improved significantly from 2013 to 2014. The rates for the following MCP counties were above the HPL for three or more consecutive years:

- ◆ Central California Alliance for Health—Monterey/Santa Cruz counties—four consecutive years
- ◆ Community Health Group Partnership Plan—San Diego County—four consecutive years
- ◆ Kaiser North—Sacramento County—three consecutive years
- ◆ Kaiser South—San Diego County—four consecutive years
- ◆ Partnership HealthPlan of California—Sonoma County—four consecutive years
- ◆ San Francisco Health Plan—San Francisco County—three consecutive years

The rates for 11 MCP counties declined significantly from 2013 to 2014, and the decline for one MCP county, CalViva Health—Kings County, resulted in the rate moving from above the MPL in 2013 to below the MPL in 2014. (Note: 2013 was the first year CalViva Health reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

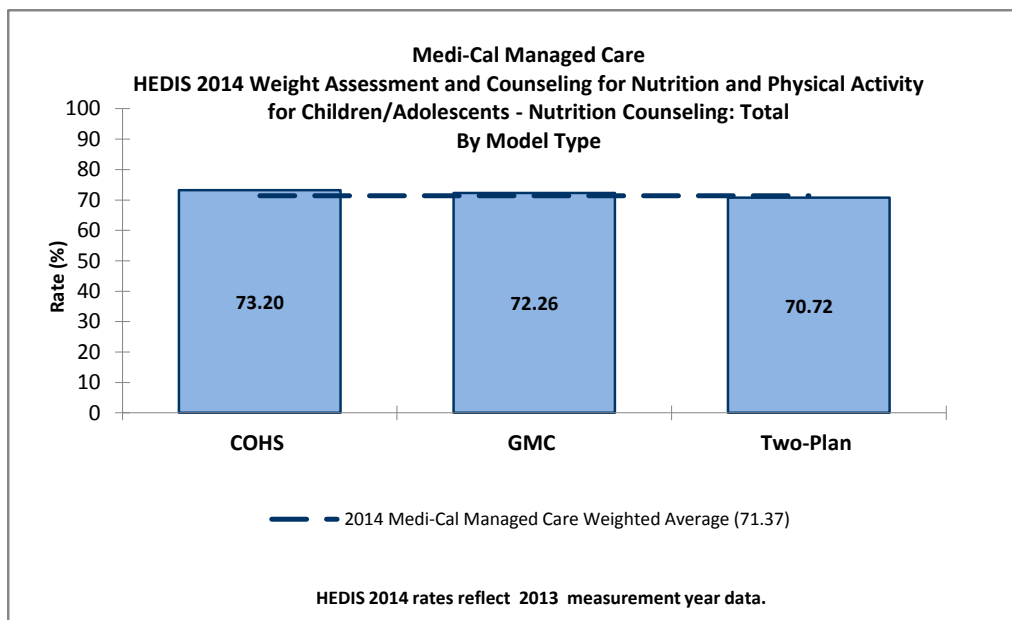
Performance Results—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total



Healthy People 2020 Goal: 22.90%

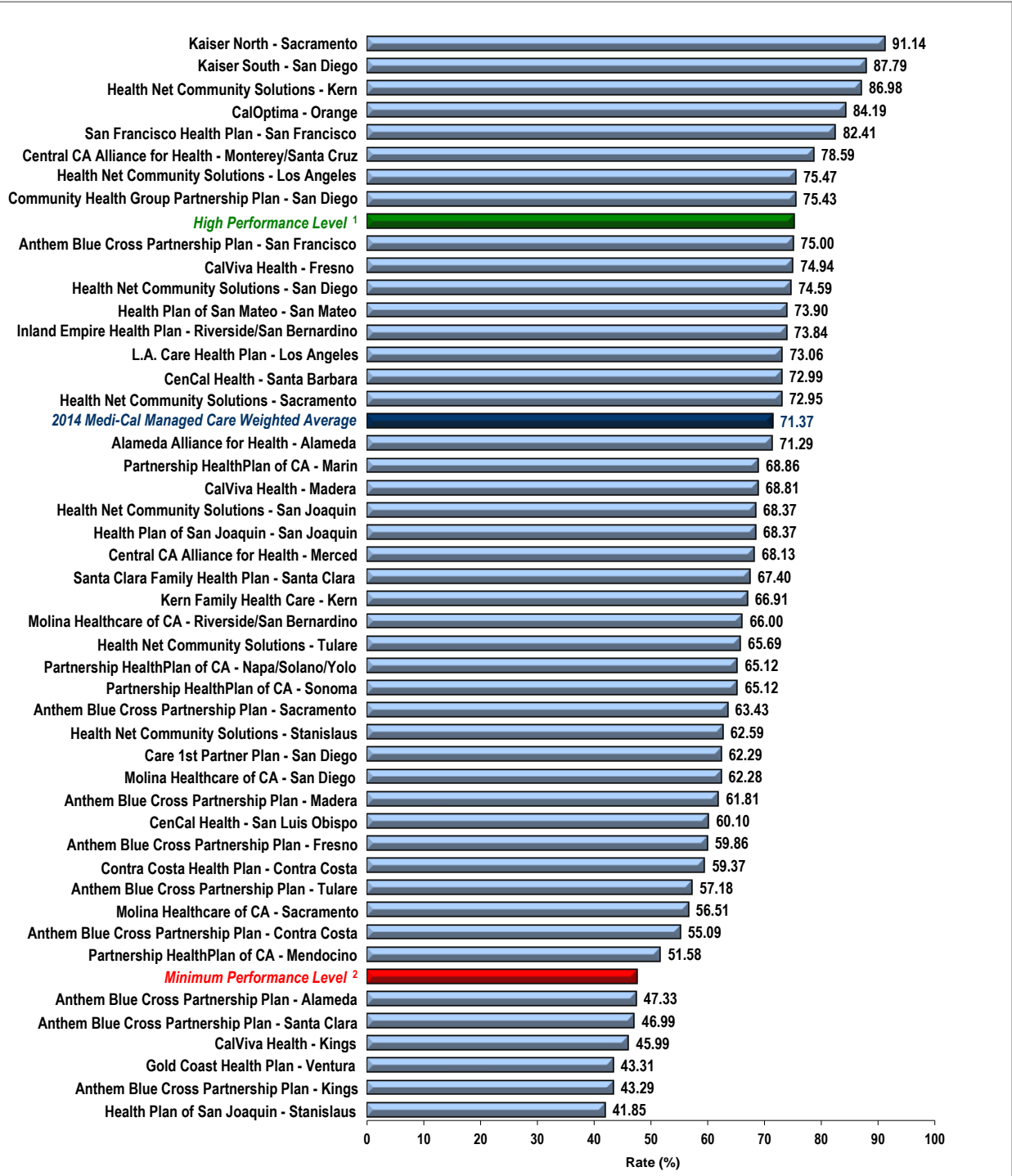
Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



HEDIS 2014 rates reflect 2013 measurement year data.

**Medi-Cal Managed Care
 HEDIS 2014 Weight Assessment and Counseling for Nutrition and Physical Activity
 for Children/Adolescents—Nutrition Counseling: Total**



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total

For the fourth consecutive year, the MCMC weighted average for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* measure was higher than the national Medicaid 25th percentile (MPL), national Medicaid and commercial averages, and Healthy People 2020 goal for this measure. The rate was below the national Medicaid 90th percentile (HPL) for the second consecutive year. The COHS model type outperformed the TPM and GMC model for the fourth consecutive year.

High and Low Performers

The rates for eight MCP counties exceeded the HPL in 2014, and the rates for the following MCP counties improved significantly from 2013 to 2014.

- ◆ Alameda Alliance for Health—Alameda County
- ◆ Health Net Community Solutions, Inc.—Kern County
- ◆ Kaiser North—Sacramento County
- ◆ Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino counties

The rates for the following MCP counties were above the HPL for three or more consecutive years:

- ◆ CalOptima—Orange County—four consecutive years
- ◆ Central California Alliance for Health—Monterey/Santa Cruz counties—four consecutive years
- ◆ Health Net Community Solutions, Inc.—Los Angeles County—four consecutive years
- ◆ Kaiser North—Sacramento County—three consecutive years
- ◆ San Francisco Health Plan—San Francisco County—four consecutive years

The rates for six MCP counties were below the MPL in 2014, and seven MCP county rates declined significantly from 2013 to 2014. The significant decline resulted in the rates for three MCP counties to move from above the MPL to below the MPL:

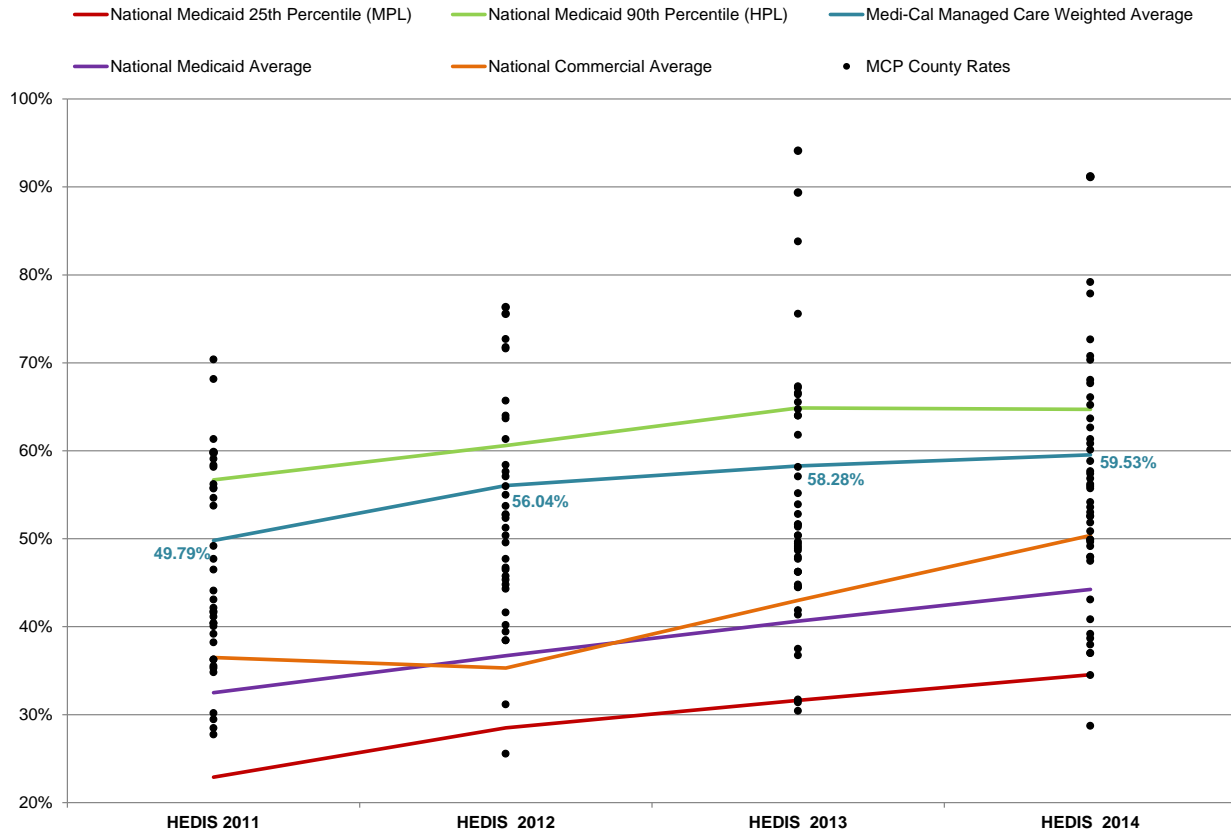
- ◆ Anthem Blue Cross Partnership Plan—Alameda County and Santa Clara County
- ◆ CalViva Health—Kings County (Note: 2013 was the first year CalViva Health reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

The rate for Anthem Blue Cross Partnership Plan—Kings County declined from 2013 to 2014, and although the decline was not statistically significant, the change resulted in the rate moving

from above the MPL to below the MPL. (Note: 2013 was the first year Anthem Blue Cross Partnership Plan reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

Note: The rate for Health Plan San Joaquin—Stanislaus County was one of the six rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MPL accountable to meet the MPL.

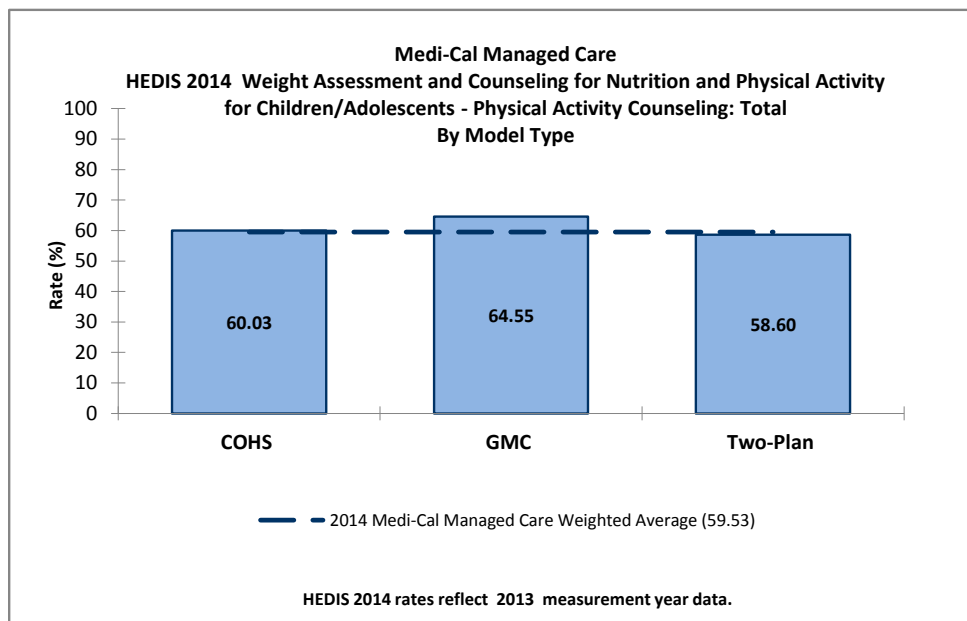
Performance Results—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescent—Physical Activity Counseling: Total



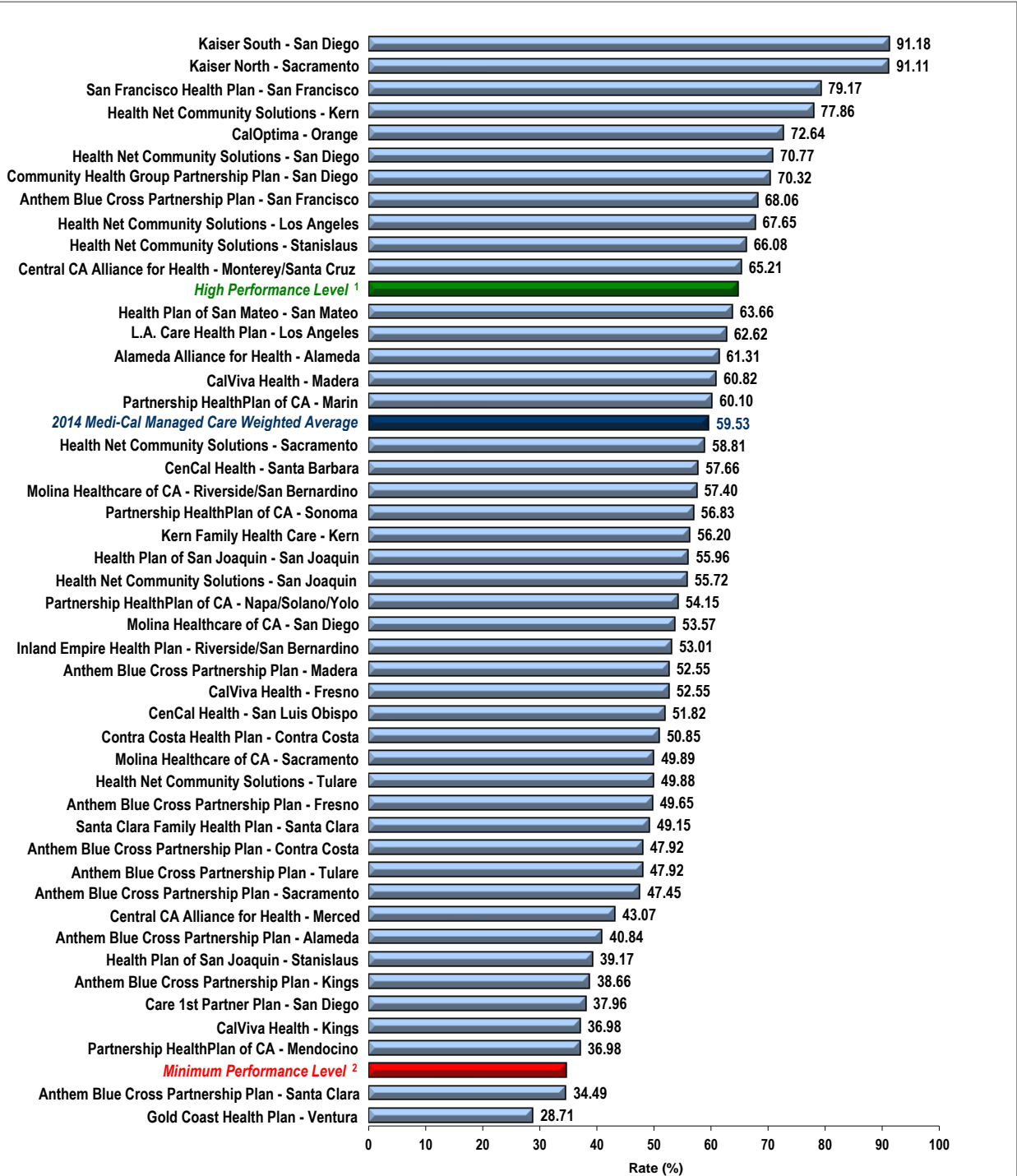
Healthy People 2020 Goal: 22.90%

Note:

- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
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**Medi-Cal Managed Care
 HEDIS 2014 Weight Assessment and Counseling for Nutrition and Physical Activity
 for Children/Adolescents—Physical Activity Counseling: Total**



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Summary of Results—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total

For the fourth consecutive year, the MCMC weighted average for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children / Adolescents—Physical Activity Counseling: Total* measure was higher than the national Medicaid 25th percentile (MPL), national Medicaid and commercial averages, and Healthy People 2020 goal for this measure. The rate remained below the national Medicaid 90th percentile (HPL). The GMC model outperformed the TPM and COHS model.

High and Low Performers

The rates for 11 MCP counties were higher than the HPL, and the rates for 12 MCP counties improved significantly from 2013 to 2014. The improvement for Anthem Blue Cross Partnership Plan—Kings County resulted in the rate for this county moving from below the MPL in 2013 to above the MPL in 2014. (Note: 2013 was the first year Anthem Blue Cross Partnership Plan reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

The rates for the following MCP counties were above the HPL for three or more consecutive years:

- ◆ Anthem Blue Cross Partnership Plan—San Francisco County—three consecutive years
- ◆ CalOptima—Orange County—four consecutive years
- ◆ Central California Alliance for Health—Monterey/Santa Cruz counties—four consecutive years
- ◆ Health Net Community Solutions, Inc.—Los Angeles County—three consecutive years
- ◆ Kaiser North—Sacramento County—four consecutive years
- ◆ Kaiser South—San Diego County—four consecutive years
- ◆ San Francisco Health Plan—San Francisco County—four consecutive years

The rates for Anthem Blue Cross Partnership Plan—Santa Clara County and Gold Coast Health Plan—Ventura County were below the MPL in 2014. The rate for Anthem Blue Cross Partnership Plan—Santa Clara County significantly declined from 2013 to 2014, which resulted in the rate being below the MPL in 2014. Two other MCP counties had rates that declined significantly from 2013 to 2014:

- ◆ Care1st Partner Plan—San Diego County
- ◆ Kaiser South—San Diego County (Although the rate for this MCP county declined significantly from 2013 to 2014, as indicated above, the rate was above the HPL in 2014.)

Best and Emerging Practices—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Educating health care professionals and providing them with the tools, skills, and knowledge necessary to identify and screen children and adolescents for overweight and obesity in a primary care setting is crucial. Physician visits offer health care providers and other clinicians the opportunity to provide preventive services, such as BMI assessments, dietary counseling, and related weight management and nutrition services. Studies indicate that adolescents view their physicians as a trustworthy source of health information and that parents want clinicians to provide these services.¹⁰⁵ Following is an example of two health plans that partnered to develop an initiative to provide education to providers that resulted in an improvement in their rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures.

AmeriHealth Mercy Health Plan and Keystone Mercy Health Plan¹⁰⁶

In 2011, AmeriHealth Mercy Health Plan and Keystone Mercy Health Plan provided information and support to members and providers to improve the quality of services and care to their pediatric population struggling with being overweight/obese. The initiatives included a care management component focused on members who meet specific criteria related to obesity and a provider education component. The provider component included the provision of instruction to PCPs regarding documentation of BMI and the proper coding of nutritional and physical activity counseling services. Additionally, providers were given packets that included:

- ◆ A BMI percentile wheel.
- ◆ An American Academy of Pediatricians clinical decision support flipchart.
- ◆ A summary of HEDIS coding guidelines.
- ◆ A provider tip sheet for effective communication with obese members.
- ◆ A BMI screening-by-category chart.

The plans reported that the most impactful intervention was the provider education component. More than 250 packets were distributed to providers, and both plans saw improvement in their three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures.

¹⁰⁵ Park MJ, Macdonald TM, Ozer EM, et al. Investing in Clinical Preventive Health Services for Adolescents. University of California, San Francisco, Policy Information and Analysis Center for Middle Childhood and Adolescence, and National Adolescent Health Information Center. 2001. Available at: <http://nahic.ucsf.edu/downloads/CPHS.pdf>. Accessed on: September 11, 2013.

¹⁰⁶ Medicaid Health Plans of America: Centers for Best Practices. *2012–2013 Best Practices Compendium*. Available at: https://www.mhpa.org/_upload/2012Compendium.pdf Accessed on: July 18, 2014

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

Measure Definition

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

Importance

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

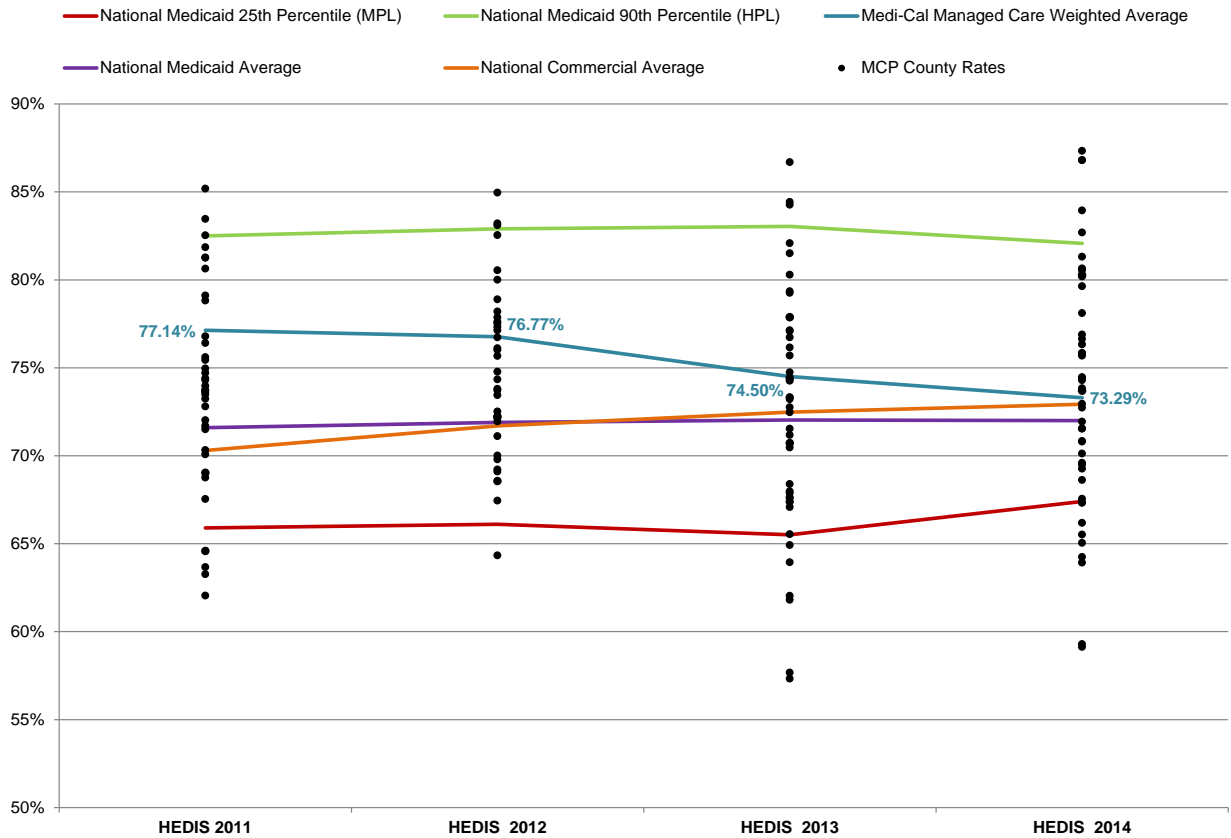
- ◆ Assessing school readiness.
- ◆ Completing preschool immunization.
- ◆ Reinforcing accident and injury prevention.
- ◆ Educating about appropriate weight.¹⁰⁷

In addition to performing preventive services, well-child visits foster communication between parents and doctors; however, between 2011 and 2012, 11 million children aged 0 to 17 years of age did not have a well-visit during the year. Regular well-visits allow doctors to offer guidance and counseling on a variety of health care topics, including safety, nutrition, normal development, and general health care, which can decrease health care costs and improve a child's health and wellness throughout life.¹⁰⁸

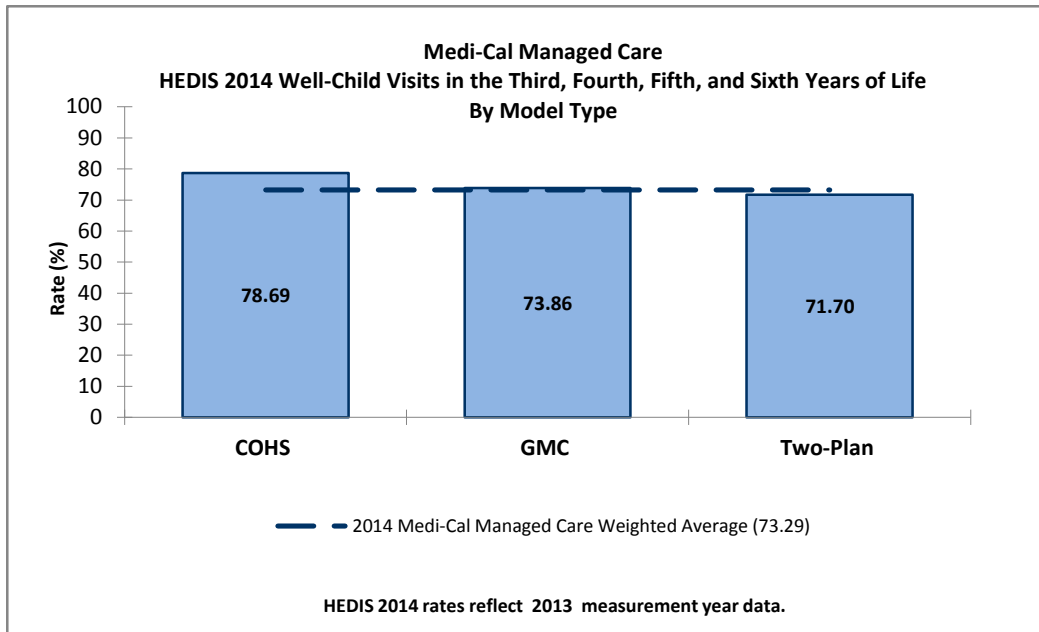
¹⁰⁷ Medicaid Managed Care Services. *Components of Well Child Screenings*. Available at: <http://mmcs.afmc.org/HealthCareProfessionals/ProviderRelations/WellChildEPSDT/ComponentsofWellChildScreenings.aspx> Accessed on: September 11, 2013.

¹⁰⁸ National Committee for Quality Assurance. *The State of Health Care Quality 2009*. Washington DC: NCQA, 2013.

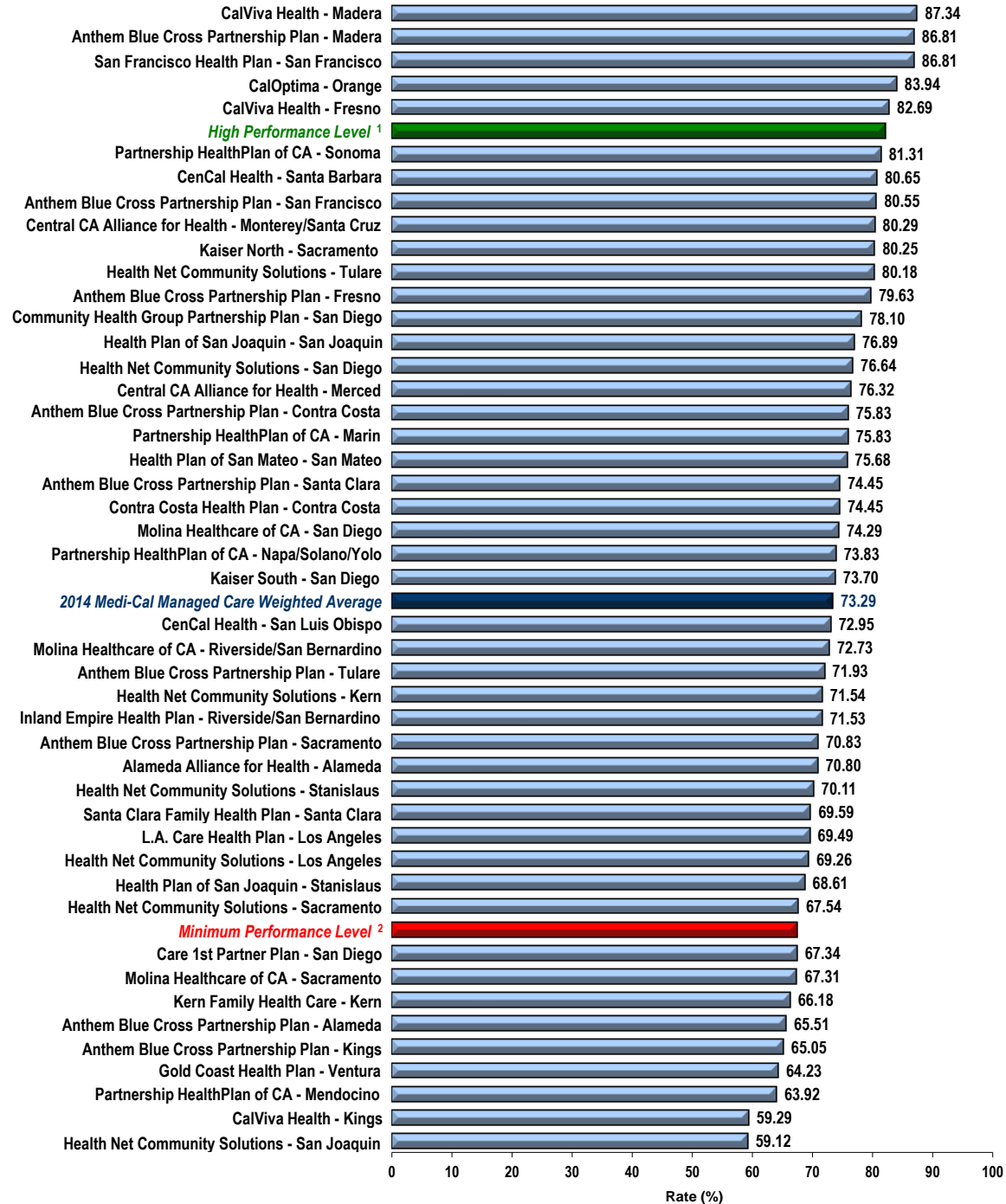
Performance Results—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life



Note:
 ♦ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
 ♦ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
 ♦ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life



¹ High Performance Level is HEDIS 2013 national Medicaid 90th Percentile.

² Minimum Performance Level is HEDIS 2013 national Medicaid 25th Percentile.

Note: HEDIS 2014 rates reflect 2013 measurement year data.

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

For the fourth consecutive year, the MCMC weighted average for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure was higher than the national Medicaid 25th percentile (MPL) and national Medicaid and commercial averages for this measure. The rate remained below the national Medicaid 90th percentile (HPL). The COHS model outperformed the TPM and GMC model for the fourth consecutive year.

High and Low Performers

The rates for the following MCP counties were above the HPL in 2014:

- ◆ Anthem Blue Cross Partnership Plan—Madera County
- ◆ CalOptima—Orange County
- ◆ CalViva Health—Fresno County and Madera County
- ◆ San Francisco Health Plan—San Francisco County (for the fourth consecutive year)

The rates for 11 MCP counties improved significantly from 2013 to 2014, and the improvement resulted in the rates for two of Anthem Blue Cross Partnership Plan's counties—Contra Costa and Tulare—to move from below the MPL in 2013 to above the MPL in 2014. Although the rates significantly improved for two other Anthem Blue Cross Partnership Plan counties—Alameda and Kings—the rates for these two counties remained below the MPL. (Note: 2013 was the first year Anthem Blue Cross Partnership Plan reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

The rates for nine MCP counties were below the MPL in 2014. (Note: The rate for Health Net Community Solutions, Inc.—San Joaquin County was one of the nine rates below the MPL in 2014; however, 2014 was the first year the MCP reported a rate for this measure for this county and DHCS therefore did not hold the MCP accountable to meet the MPL).

The rates for CalViva Health—Kings County and Health Net Community Solutions, Inc.—Los Angeles County declined significantly from 2013 to 2014. The decline in the rate for CalViva Health—Kings County resulted in the rate moving from above the MPL to below the MPL. (Note: 2013 was the first year CalViva Health reported a rate for Kings County, so DHCS did not hold the MCP accountable to meet the MPL for this county in 2013).

The rates for three MCP counties declined from 2013 to 2014, and although the decline was not statistically significant, the rates for the MCP counties moved from above the MPL in 2013 to below the MPL in 2014:

- ◆ Care1st Partner Plan—San Diego County

- ◆ Kern Family Health Care—Kern County
- ◆ Molina Healthcare of California Partner Plan, Inc.—Sacramento County

Best and Emerging Practices—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

University of Oklahoma Health Sciences Center¹⁰⁹

Members of the Department of Family and Preventive Medicine at the University of Oklahoma Health Sciences Center contracted to help provider practices improve the rates and quality of well-child visits within the Oklahoma Medicaid Program. Sixteen pediatric and family medicine practices in three Oklahoma counties participated in the initiative. Performance feedback was given to the providers on the rate and quality of well-child visits that occurred during the previous twelve months. Additionally, the providers were given a copy of the practice guidelines, the Oklahoma Medicaid requirements, and tips from exemplary practices. In two of the counties, a case manager helped the practices with challenging patients. Practice enhancement assistants then helped providers implement a variety of strategies to increase the well-child visit rates and improve the quality of early and periodic screening, diagnosis, and treatment visits. When needed, information technology support was provided. The average rates of well-child visits for all counties combined increased. Visit rates increased more in the younger age groups (birth to two years). There also was significant improvement in quality of visits.

Children's Preventive Healthcare Initiative¹¹⁰

IHI provides information about the Children's Preventive Healthcare Initiative, which aimed to increase well-child visits and immunization rates for children enrolled in the Washington Medicaid program by 10 percentage points. Of the 11 clinics that participated in the initiative, nine completed at least one quality improvement project using the Model for Improvement, which is the framework IHI uses to guide improvement work. Changes designed and implemented to improve well-child visits included:

- ◆ Developing postcard and telephone outreach to parents of infants and children overdue for a well-child visit.
- ◆ Offering incentives to parents for making and keeping the well-child visit appointment.

¹⁰⁹ Smith KD, Merchen E, Turner CD, Vaught C, Fritz T, Mold J. Improving the Rate and Quality of Well Child Care Exams in Primary Care Practices. *The Journal of the Oklahoma State Medical Association*. 2010; Jul;103(7):248-53.

¹¹⁰ Institute for Healthcare Improvement. Improvement Stories. Children's Preventive Healthcare Initiative. Available at: <http://www.ihc.org/resources/Pages/ImprovementStories/ChildrensPreventiveHealthcareInitiative.aspx>. Accessed on: August 13, 2014.

- ◆ Developing a process for physicians and nurses to remind the parent, during sick visits, to schedule a well-child visit.
- ◆ Developing bilingual reminder postcards.
- ◆ Adopting the State well-child visit charting tool.
- ◆ Developing a system to identify the children overdue for a well-child visit using clinic billing data or managed care health plan data.

The initiative established a unique cooperative effort between state policymakers, health plan representatives, and frontline clinic staff to improve health care for Washington's Medicaid children. A key component was that the exchange of information was fluid and productive across participants. Additionally, the clinics helped each other on their individual quality improvement projects.

6. SPECIALTY MCP PERFORMANCE MEASURE RESULTS

DHCS contracts with three specialty MCPs. These MCPs are required to report two performance measures annually. In collaboration with DHCS, a specialty MCP may select measures from HEDIS or design a measure that is appropriate to the MCP's population. The measures put forth by the specialty MCPs are subject to approval by DHCS. Furthermore, specialty MCPs must report performance measure results specific to MCMC members. This section includes results from the specialty MCPs' 2014 performance measures, which reflect data from January 1, 2013, to December 31, 2013.

AHF Healthcare Centers

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

AHF's 2014 performance measures were the HEDIS measures *Controlling High Blood Pressure* and *Colorectal Cancer Screening*.

Controlling High Blood Pressure

Measure Definition

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

Importance

In 2012, approximately 76.4 million people over the age of 20 have high blood pressure (hypertension) in the United States. Hypertension was the cause of 61,005 deaths in the United States in 2008. Hypertension is considered to be a "silent" condition. Fortunately, high blood pressure is easily detected and usually controllable.¹¹¹

¹¹¹ American Heart Association. Statistical Fact Sheet 2012 Update. High Blood Pressure. Available at: http://www.heart.org/idc/groups/heart-public/@wcm/@sop/@smd/documents/downloadable/ucm_319587.pdf. Accessed on: September 11, 2013.

Controlling high blood pressure is important since it can lead to many further complications. Complications due to high blood pressure include:¹¹²

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

Performance Results—Controlling High Blood Pressure

Table 6.1—Controlling High Blood Pressure Rates for AHF Healthcare Centers

Year	2012 ²	2013	2014	Performance Comparison ³
Rate ¹	68.2%	62.20%	61.07%	↔
Healthy People 2020 Goal	61.20%	61.20%	61.20%	N/A

¹ If the rate is **bolded**, it was below the minimum performance level (MPL), which is based on the national Medicaid 25th percentile; and if the rate is shaded, it was above the high performance level (HPL), which is based on the national Medicaid 90th percentile.

² Rates in 2012 were reported to one decimal place. To be consistent with NCQA, rates starting in 2013 are reported to two decimal places.

³ The 2014 rates were compared to the 2013 rates to determine if there were any statistically significant differences between the two rates. Performance comparisons were based on the Chi-square test of statistical significance with a *p* value of <0.05.

↓ = Statistically significant decrease.

↔ = No statistically significant change.

↑ = Statistically significant increase.

Summary of Results—Controlling High Blood Pressure

The MCP’s rate for the *Controlling High Blood Pressure* measure showed no statistically significant change from 2013 to 2014. The rate declined by just over 1 percentage point, which resulted in the rate no longer exceeding the Healthy People 2020 goal.

¹¹² The Mayo Clinic: High blood pressure (hypertension). Complications. Updated August 2012. Available at: <http://www.mayoclinic.com/health/high-blood-pressure/DS00100/DSECTION=complications>. Accessed on: September 11, 2013.

Colorectal Cancer Screening

Measure Definition

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

Importance¹¹³

Not counting skin cancers, colorectal cancer is the third most common cancer found in men and women in the United States. Overall, the lifetime risk of developing colorectal cancer is about 1 in 20. Colorectal cancer is the third leading cause of cancer-related deaths in the United States when men and women are considered separately, and the second leading cause of death when both sexes are combined. The death rate from colorectal cancer has been declining for more than 20 years. One reason is that there are fewer cases, and with preventive colorectal cancer screening, polyps can be found and removed before they become cancerous.

The American Cancer Society's most recent estimates for colorectal cancer in the United States are for 2014:

- ◆ About 96,830 new cases of colon cancer.
- ◆ About 40,000 new cases of rectal cancer.
- ◆ About 50,310 deaths from colorectal cancer.

Colorectal cancer screening saves lives. Screening can find precancerous polyps—abnormal growths in the colon or rectum—so that they can be removed before turning into cancer. Screening also helps find colorectal cancer at an early stage, when treatment often leads to a cure.

¹¹³ American Cancer Society. What are the key statistics about colorectal cancer? Available at: <http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics>. Accessed on: September 5, 2014.

Performance Results—Colorectal Cancer Screening

Table 6.2—Colorectal Cancer Screening Rates for AHF Healthcare Centers

Year	2012 ²	2013	2014	Performance Comparison ³
Rate ¹	64.2%	63.07%	52.04%	↓
Healthy People 2020 Goal	70.50%	70.50%	70.50%	N/A

¹ If the rate is **bolded**, it was below the minimum performance level (MPL), which is based on the national commercial 25th percentile; and if the rate is shaded, it was above the high performance level (HPL), which is based on the national commercial 90th percentile. Commercial benchmarks are used because there are no Medicaid benchmarks for this measure.

² Rates in 2012 were reported to one decimal place. To be consistent with NCQA, rates starting in 2013 are reported to two decimal places.

³ The 2014 rates were compared to the 2013 rates to determine if there were any statistically significant differences between the two rates. Performance comparisons were based on the Chi-square test of statistical significance with a *p* value of <0.05.

↓ = Statistically significant decrease.

↔ = No statistically significant change.

↑ = Statistically significant increase.

Summary of Results—Colorectal Cancer Screening

AHF Healthcare Center's rate for the *Colorectal Cancer Screening* measure declined significantly from 2013 to 2014, resulting in the rate being below the MPL, which is based on the national commercial 25th percentile since there are no Medicaid benchmarks for this measure. The MCP's rate for the measure also fell below the Healthy People 2020 goal for the third consecutive year.

Family Mosaic Project

Family Mosaic Project, operated by the City and County of San Francisco Department of Public Health, is a specialty MCP in San Francisco County. Family Mosaic Project became operational with MCMC in February 1993.

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

Due to the unique services Family Mosaic Project provides, standardized HEDIS measures are not appropriate. For 2014, the MCP reported on the *Out-of-Home Placements* measure for the third consecutive year and on a new measure, *School Attendance*, which was developed in consultation with HSAG and approved by DHCS.

Reduce Rate of Out-of-Home Placements

Measure Definition

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

Importance

Research has shown adverse effects on the health and well-being of children and adolescents who were placed out-of-home in foster care, group home, and residential treatment facilities, as well as community treatment facilities.¹¹⁴ Out-of-home placements can be overly restrictive and contribute to behavioral health deterioration. Ensuring that members are maintained in a home-like setting is one goal of Family Mosaic Project.

¹¹⁴ Family Mosaic Project. Quality Improvement Project, *Reducing the Rate of Out-of-Home Placements*, 2010 submission.

Performance Results—Out-of-Home Placements

Table 6.3—Out-of-Home Placements Rates* for Family Mosaic Project

Year	2012	2013	2014	Performance Comparison ²
Rate ¹	6.3%	4.1%	S	↔

* There is no MPL or HPL for this measure.

¹ The rate for this measure was reported to one decimal place in 2012 and 2013; however, in 2014, the rate was reported to two decimal places.

² The 2014 rates were compared to the 2013 rates to determine if there were any statistically significant differences between the two rates. Performance comparisons were based on the Chi-square test of statistical significance with a p value of <0.05 .

S = The MCP's measure was reportable based on performance measure validation audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

↓ = Statistically significant decrease.

↔ = No statistically significant change.

↑ = Statistically significant increase.

Summary of Results—Out of Home Placements

The rate of *Out-of-Home Placements* declined from 2013 to 2014. The percentage decrease in the rate for this measure reflected an improvement in performance, although the change was not statistically significant.

School Attendance

Measure Definition

The *School Attendance* measure indicates the number of capitated Medi-Cal managed care members enrolled into Family Mosaic Project with a 2 or 3 in school attendance on the initial Child and Adolescent Needs and Strengths (CANS) outcome/assessment tool and a 2 or 3 in school attendance on the most recent closing CANS during the measurement period.

- ◆ 0 = Child/youth attends school regularly.
- ◆ 1 = Child/youth has some problems attending school but generally goes to school. May miss up to one day per week on average OR may have moderate to severe problem in the past six months but has been attending school regularly in the past month.
- ◆ 2 = Child/youth is having problems with school attendance. He/she is missing at least two days per week.
- ◆ 3 = Child/youth is generally truant or refusing to go to school/mental health admission to an inpatient hospital facility during the measurement period.

Importance

Family Mosaic Project's data showed that school attendance is a marked problem for children and youth within the MCP. In response, Family Mosaic Project focused on increasing the rate of school attendance for its members aged 6 to 18 years. Using the CANS outcome/assessment tool, the MCP aimed to reduce the percentage of members identified in the tool as having missed school at least two days per week on average, were generally truant, or refused to go to school.

Performance Results—School Attendance

Table 6.4—School Attendance* for Family Mosaic Project

Year	2014
Rate	S

* There is no MPL or HPL for this measure.

S = The MCP's measure was reportable based on performance measure validation audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Summary of Results—School Attendance

Since this is the first year Family Mosaic Project reported the *School Attendance* measure, no analysis or comparison can be done.

SCAN Health Plan

SCAN Health Plan is a Fully-Integrated Dual-Eligible Special Needs Plan (FIDE-SNP) that contracts with DHCS as a specialty MCP for elderly members who reside in Los Angeles, Riverside, and San Bernardino counties and who are dually eligible under both the Medicare and Medi-Cal programs.

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

SCAN Health Plan's 2014 performance measures were the *Breast Cancer Screening* and *Osteoporosis Management in Women Who Had a Fracture* HEDIS measures. Since SCAN Health Plan participates in the *All-Cause Readmissions* statewide collaborative QIP, the MCP also reported a rate for the *All-Cause Readmissions* measure, which is a non-HEDIS measure.

Breast Cancer Screening

Measure Definition

The *Breast Cancer Screening* measure is reported using only the administrative method. This measure calculates the percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer.

Importance

Breast cancer is one of the most prevalent cancers and is the second leading cause of cancer deaths among women. There is a one-in-eight lifetime risk that a woman in the United States will develop breast cancer.¹¹⁵ The risk factors and mortality rate vary across age and racial/ethnic groups. Although breast cancer rates are higher among Caucasian women, the breast cancer mortality rate is higher in African American women. Older women are more at risk for breast cancer than younger women. Women aged 50 years and older have an 80 percent chance of developing breast cancer. Since there is no cure, early detection is the key in fighting breast cancer.¹¹⁶

¹¹⁵ National Committee for Quality Assurance. *The State of Health Care Quality 2013*: NCQA; 2013.

¹¹⁶ Susan G. Komen Foundation. *About Breast Cancer*. Available at: <http://www.komenmifitl.org/understanding-breast-cancer/about-breast-cancer/>. Accessed on June 30, 2014.

Since breast cancer is not preventable, screening tests that allow for the detection of cancer in the early stages is the preeminent method to reduce mortality.¹¹⁷ Screenings typically detect tumors at an earlier stage of development (i.e., Stage I) than those found outside of screening and can detect cancer in women without symptoms.^{118,119} For women 50 to 69 years of age, mammogram screenings decrease breast cancer mortality by up to 35 percent.¹²⁰

In addition to the personal loss, breast cancer accounts for substantial costs to the U.S. health care system. It is estimated that breast cancer in the United States costs \$7 billion per year, and a significant portion is spent on late-stage treatment. Treatment for breast cancer detected in earlier stages costs significantly less than treatment for more advanced stages.¹²¹

Performance Results—Breast Cancer Screening

Table 6.5—Breast Cancer Screening Rates for SCAN Health Plan

Year	2012 ²	2013	2014	Performance Comparison ³
Rate ¹	79.9%	81.42%	74.90%	↓
Healthy People 2020 Goal	81.10%	81.10%	81.10%	N/A

¹ If the rate is **bolded**, it was below the minimum performance level (MPL), which is based on the national Medicaid 25th percentile; and if the rate is shaded, it was above the high performance level (HPL), which is based on the national Medicaid 90th percentile.

² Rates in 2012 were reported to one decimal place. To be consistent with NCQA, rates starting in 2013 are reported to two decimal places.

³ The 2014 rates were compared to the 2013 rates to determine if there were any statistically significant differences between the two rates. Performance comparisons were based on the Chi-square test of statistical significance with a *p* value of <0.05.

↓ = Statistically significant decrease.

↔ = No statistically significant change.

↑ = Statistically significant increase.

Summary of Results—Breast Cancer Screening

Although SCAN Health Plan's rate for the *Breast Cancer Screening* measure declined significantly from 2013 to 2014, the rate was above the national Medicaid 90th percentile (HPL) for the second consecutive year. The decline in the rate, however, resulted in the rate moving from higher than the Healthy People 2020 goal in 2013 to lower than the Healthy People 2020 goal in 2014.

¹¹⁷ USPSTF. Screening for breast cancer: U.S. Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine*. 2009; 151(10): 716–726, W-236.

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

¹¹⁹ Redondo, Maximino, Funez, Rafael, Medina-Cano, Francisco, et al. Detection Methods Predict Differences in Biology and survival in Breast Cancer Patients. *BMC Cancer*. 2012; 12(604). Available at: <http://www.biomedcentral.com/1471-2407/12/604>. Accessed on June 30, 2014.

¹²⁰ National Committee for Quality Assurance. *The State of Health Care Quality 2009*: NCQA; 2009.

¹²¹ National Committee for Quality Assurance. *The State of Health Care Quality 2013*: NCQA; 2013.

Osteoporosis Management in Women Who Had a Fracture

Measure Definition

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

Importance

Osteoporosis is a skeletal disorder characterized by compromised bone strength that puts a person at increased risk for fractures. Morbidity and mortality related to osteoporotic fractures are major health issues. Nine million Americans have osteoporosis, and another 48 million are at risk for osteoporosis due to low bone mass. Eighty percent of people with osteoporosis are women. Approximately 1.5 million fractures annually can be linked to osteoporosis.¹²²

Treatment of osteoporosis and fractures is estimated at \$17–22 billion annually in the United States. It is estimated that there will be a 50 percent increase in the number of fractures and costs associated with those fractures by 2025.¹²³ The aging United States population is likely to increase the future financial cost of osteoporosis care.

Performance Results—Osteoporosis Management in Women Who Had a Fracture

Table 6.6—Osteoporosis Management in Women Who Had a Fracture Rates for SCAN Health Plan

Year	2012 ²	2013	2014	Performance Comparison ³
Rate ¹	27.7%	28.40%	41.14%	↑

¹ If the rate is **bolded**, it was below the minimum performance level (MPL), which is based on the national Medicare 25th percentile; and if the rate is shaded, it was above the high performance level (HPL), which is based on the national Medicare 90th percentile.

² Rates in 2012 were reported to one decimal place. To be consistent with NCQA, rates starting in 2013 are reported to two decimal places.

³ The 2014 rates were compared to the 2013 rates to determine if there were any statistically significant differences between the two rates. Performance comparisons were based on the Chi-square test of statistical significance with a *p* value of <0.05.

↓ = Statistically significant decrease.

↔ = No statistically significant change.

↑ = Statistically significant increase.

¹²² Ibid.

¹²³ National Committee for Quality Assurance. *The State of Health Care Quality 2013*: NCQA; 2013.

Summary of Results—Osteoporosis Management in Women Who Had a Fracture

SCAN Health Plan’s rate for the *Osteoporosis Management in Women Who Had a Fracture* measure improved significantly from 2013 to 2014, demonstrating that the MCP’s efforts were successful at increasing the percentage of women 67 years of age and older who suffered a fracture, and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

All-Cause Readmissions

Measure Definition

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

Importance

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

Performance Results

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

Table 6.7—All Cause Readmissions Rates for SCAN Health Plan

Year	2013	2014	Performance Comparison ¹
SPD Rate	14.10%	10.07%	▲
Non-SPD Rate	0.00%*	27.40%	↔
Total (SPD and Non-SPD) Rate	14.06%	12.37%	↔

¹ The 2014 rates were compared to the 2013 rates to determine if there were any statistically significant differences between the two rates. Performance comparisons were based on the Chi-square test of statistical significance with a *p* value of <0.05.

* The numerator for the Non-SPD population was 0 and the denominator was 3. The MCP reported a 0.00% rate rather than an “NA.”

↔ = Rates in 2014 were not significantly different than they were in 2013.

An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

DHCS did not establish an MPL or HPL for the *All-Cause Readmissions* measure.

7. AMBULATORY CARE USE OF SERVICES MEASURE RESULTS

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

Ambulatory Care

Measure Definition

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

- ◆ Outpatient visits
- ◆ Emergency department (ED) visits

Outpatient visits include office visits or routine visits to hospital outpatient departments. Emergency rooms often deliver nonemergency care.¹²⁴

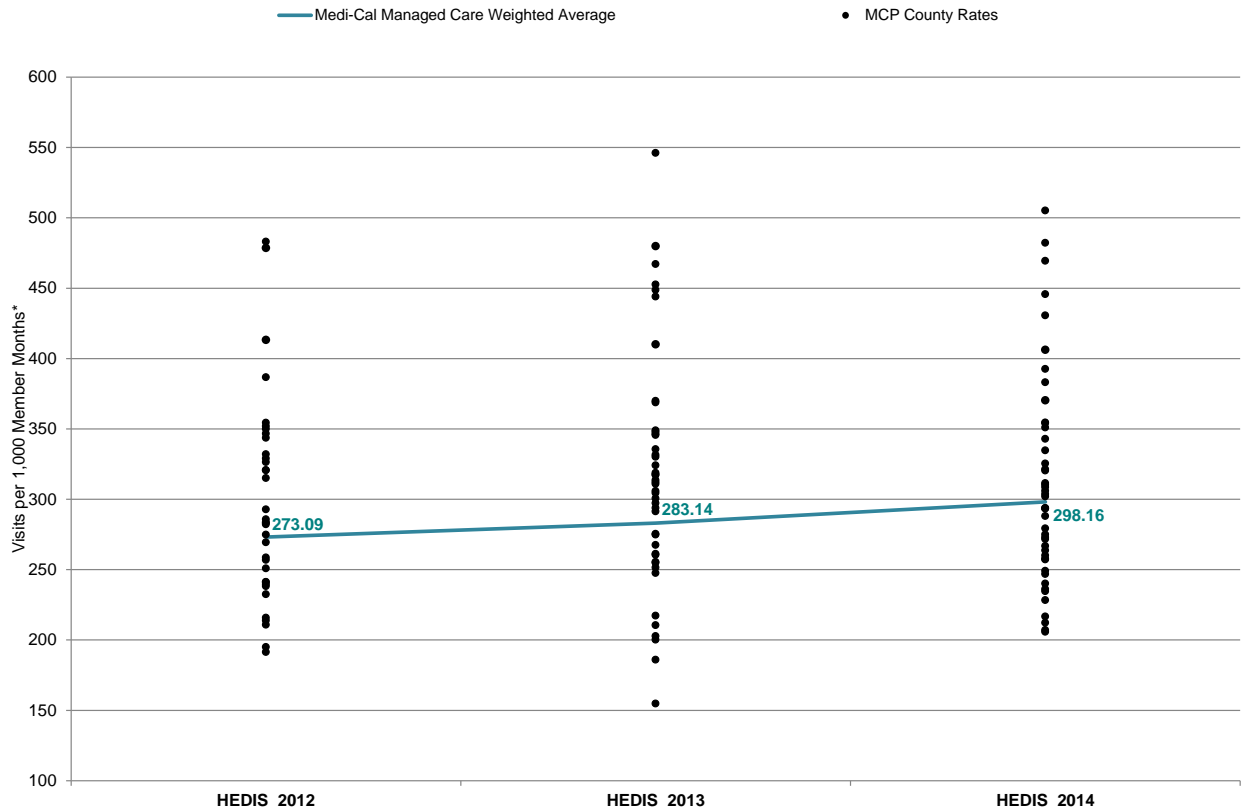
Importance

Use of services measures provide information about how MCPs manage the provision of care to their members and use and manage resources. However, use of services measures are not totally controlled by the MCPs and are affected by many member characteristics, which can vary greatly among MCPs, and include age and sex, current medical condition, socioeconomic status, and regional practice patterns. The results of these measures should be considered informational and a starting point for discussion about how resources are used, the extent of care, and possible inappropriate care.¹²⁵

¹²⁴ National Quality Measures Clearinghouse. Measure Summary, *Ambulatory care: summary of utilization of ambulatory care in the following categories: outpatient visits and emergency department visits*. AHRQ. 2010. Available at: <http://www.qualitymeasures.ahrq.gov/content.aspx?id=34130>. Accessed on: September 11, 2013.

¹²⁵ Ibid.

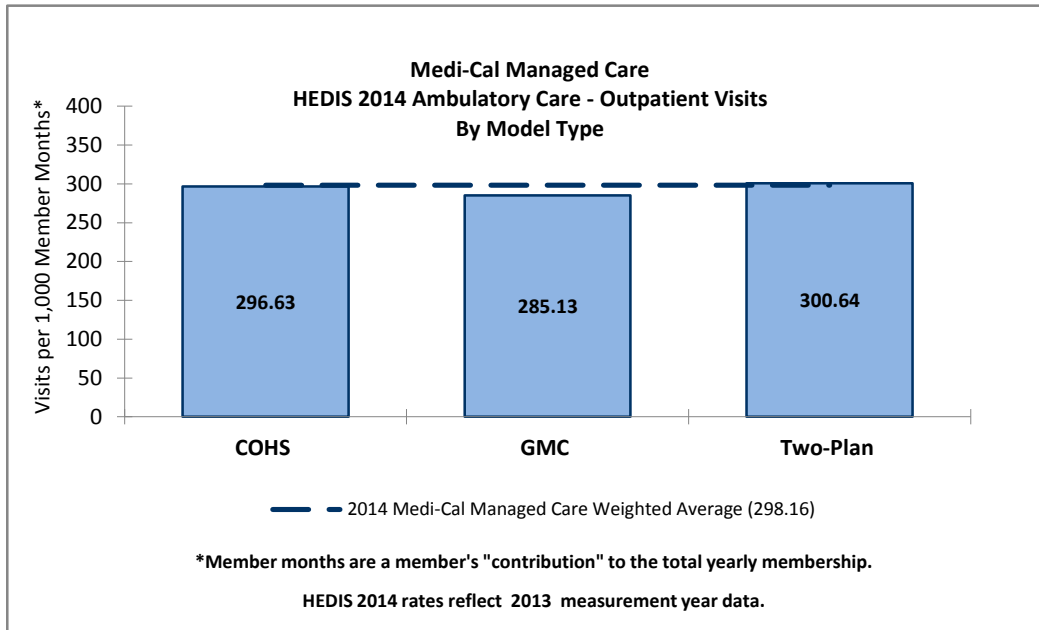
Performance Results—Ambulatory Care—Outpatient Visits



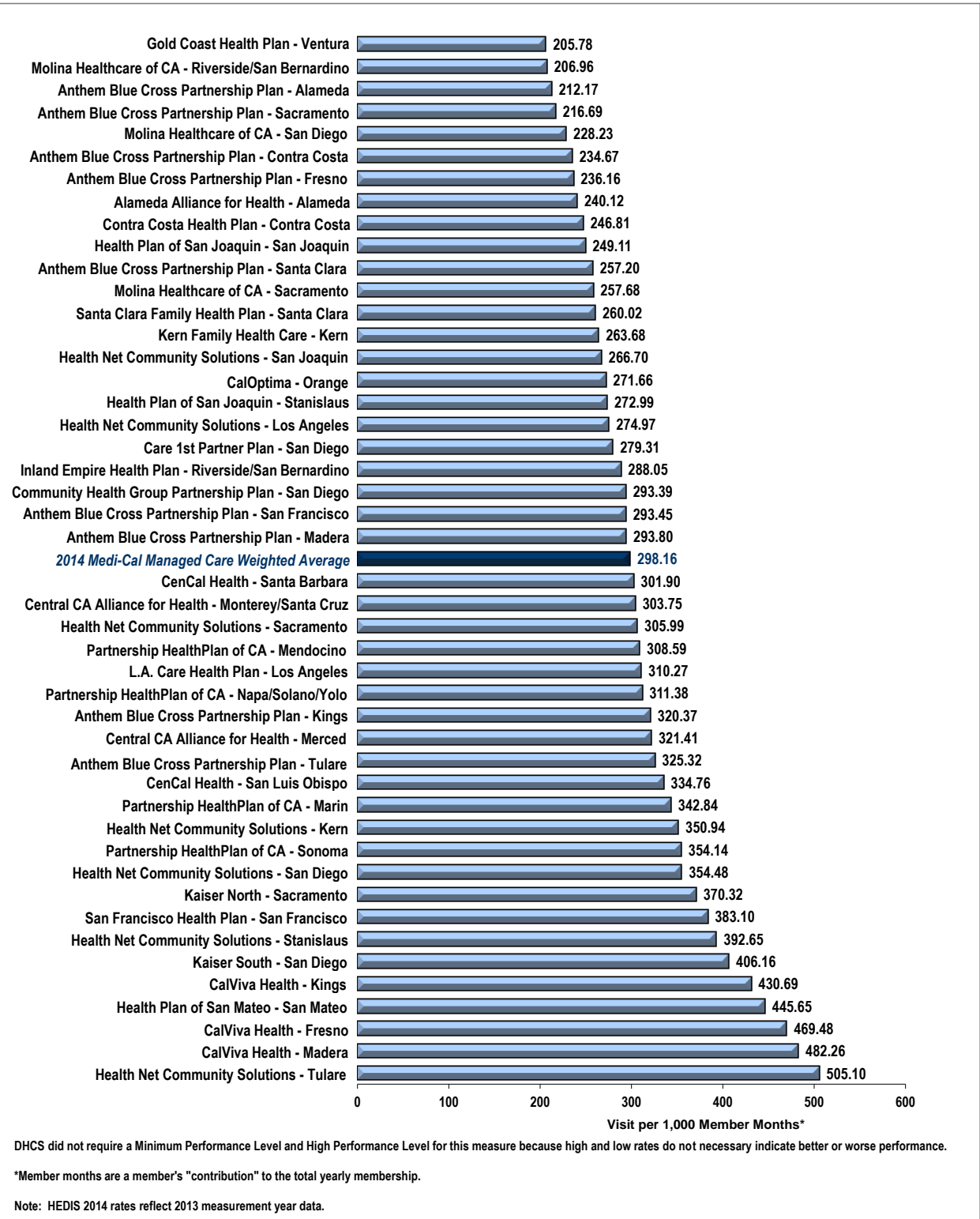
* Member months are a member's "contribution" to the total yearly membership.

Note:

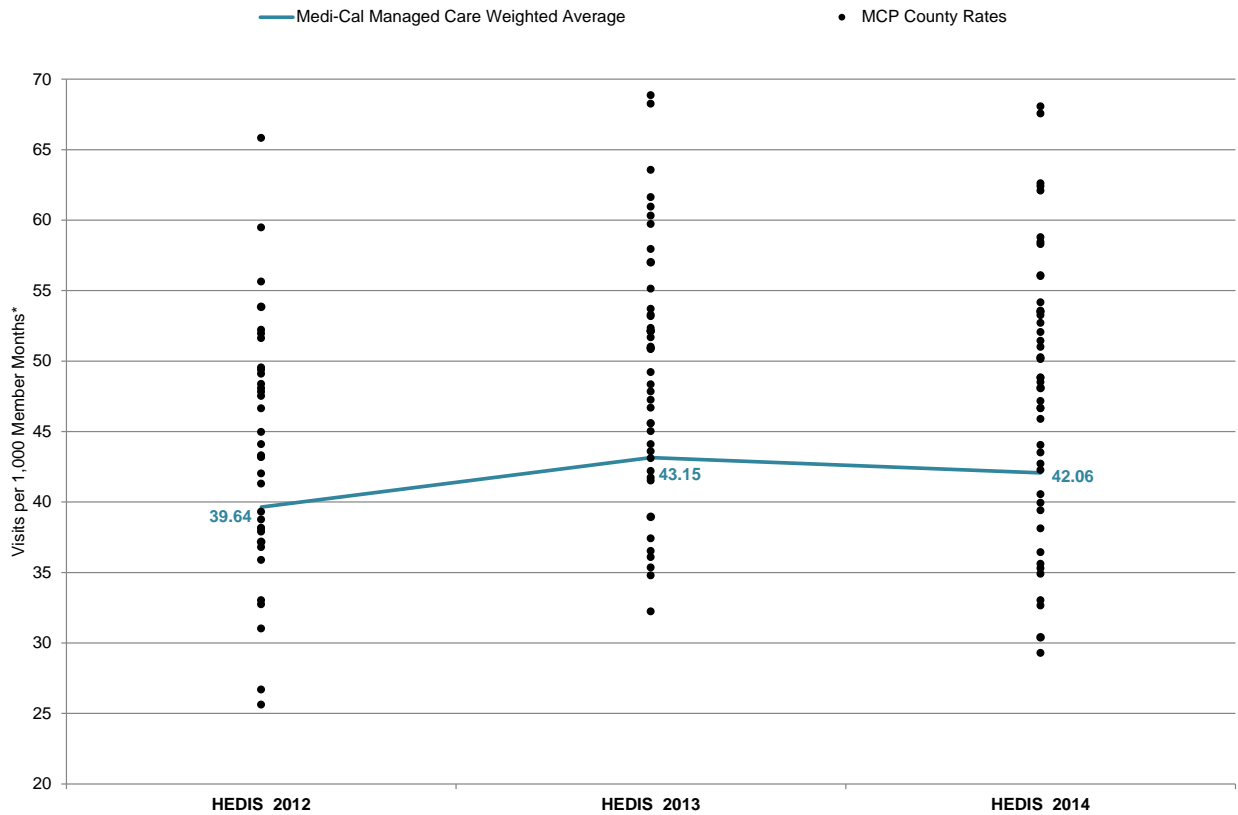
- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



Medi-Cal Managed Care
 HEDIS 2014 Ambulatory Care—Outpatient Visits



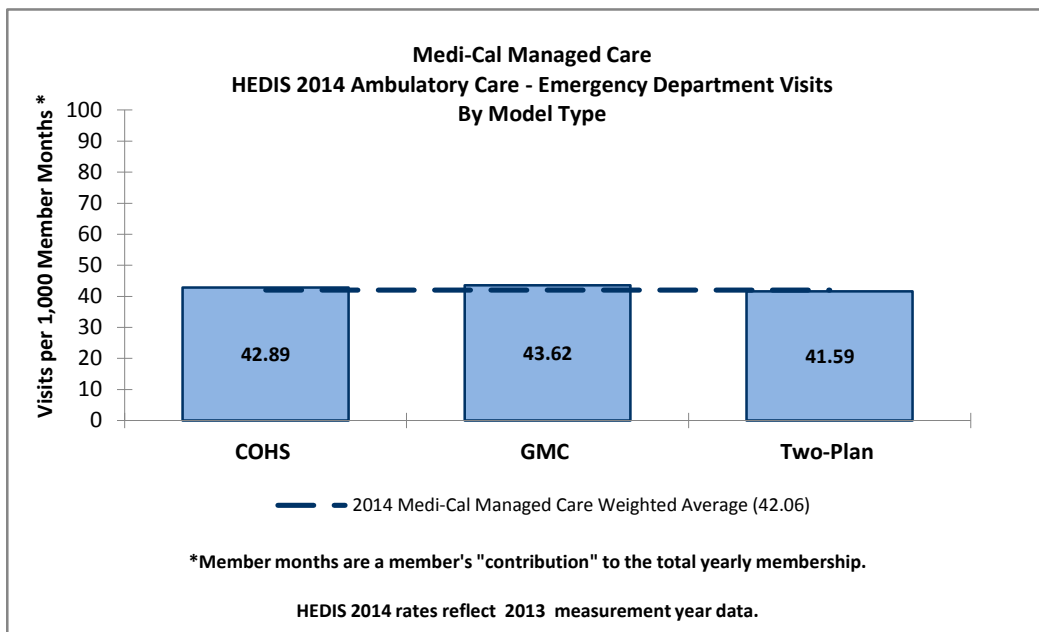
Performance Results—Ambulatory Care—Emergency Department Visits



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

Note:

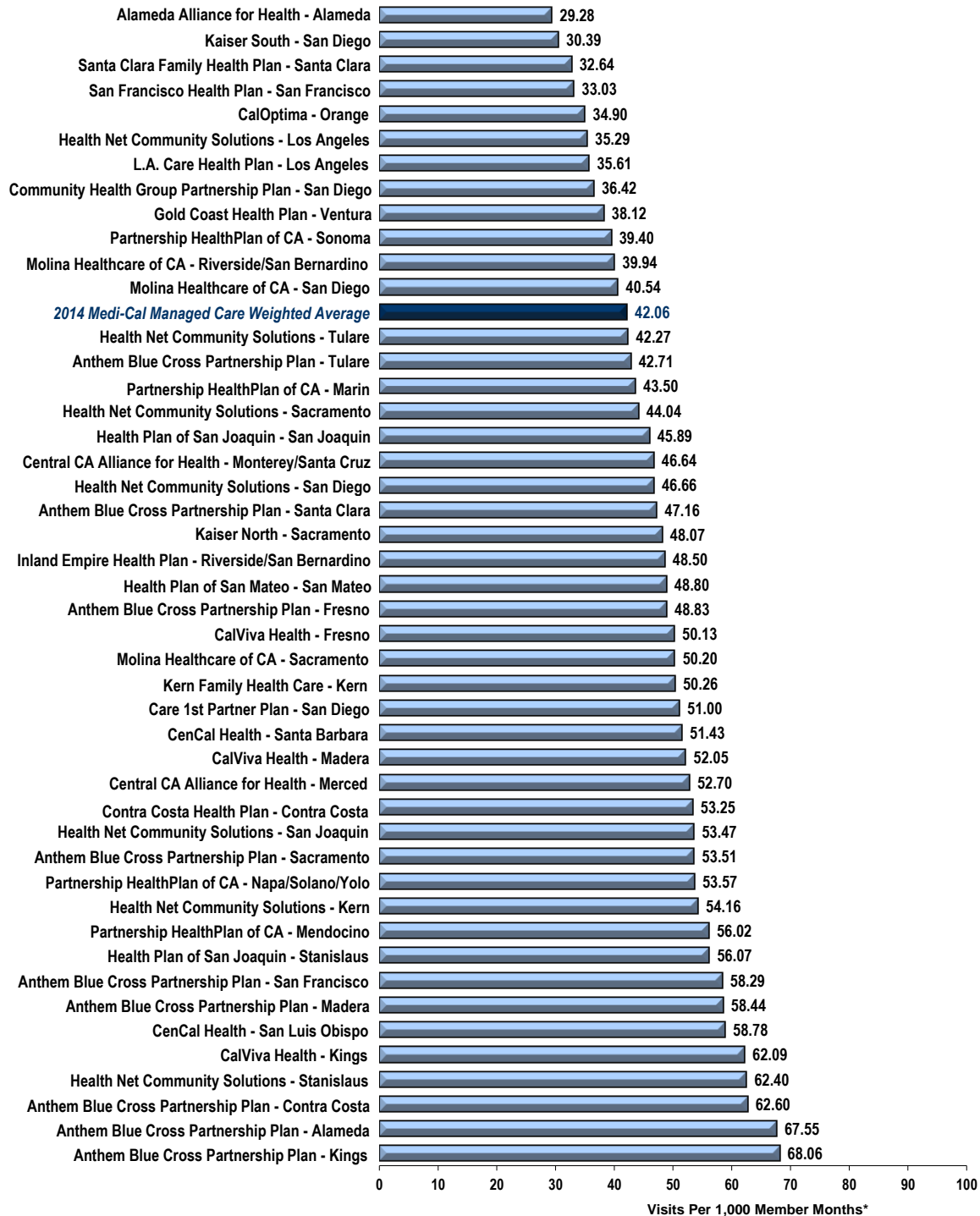
- ◆ The percentages displayed on this chart represent the Medi-Cal Weighted Average for each year displayed.
- ◆ Not all MCP counties that contributed to the previous years' Medi-Cal Weighted Averages are shown.
- ◆ Only MCP counties that reported data for HEDIS 2014 are shown and these MCP counties may not have reported data in prior years.



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

HEDIS 2014 rates reflect 2013 measurement year data.

Medi-Cal Managed Care
 HEDIS 2014 Ambulatory Care—Emergency Department Visits



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

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

Note: HEDIS 2014 rates reflect 2013 measurement year data.

Table 7.1—HEDIS 2014 Medi-Cal Managed Care Ambulatory Care Measure

MCP Name	County	Outpatient Visits	ED Visits
Alameda Alliance for Health	Alameda	240.12	29.28
Anthem Blue Cross Partnership Plan	Alameda	212.17	67.55
Anthem Blue Cross Partnership Plan	Contra Costa	234.67	62.60
Anthem Blue Cross Partnership Plan	Fresno	236.16	48.83
Anthem Blue Cross Partnership Plan	Kings	320.37	68.06
Anthem Blue Cross Partnership Plan	Madera	293.80	58.44
Anthem Blue Cross Partnership Plan	Sacramento	216.69	53.51
Anthem Blue Cross Partnership Plan	San Francisco	293.45	58.29
Anthem Blue Cross Partnership Plan	Santa Clara	257.20	47.16
Anthem Blue Cross Partnership Plan	Tulare	325.32	42.71
CalOptima	Orange	271.66	34.90
CalViva Health	Fresno	469.48	50.13
CalViva Health	Kings	430.69	62.09
CalViva Health	Madera	482.26	52.05
Care1st Partner Plan	San Diego	279.31	51.00
CenCal Health	San Luis Obispo	334.76	58.78
CenCal Health	Santa Barbara	301.90	51.43
Central CA Alliance for Health	Merced	321.41	52.70
Central CA Alliance for Health	Monterey/Santa Cruz	303.75	46.64
Community Health Group Partnership Plan	San Diego	293.39	36.42
Contra Costa Health Plan	Contra Costa	246.81	53.25
Gold Coast Health Plan	Ventura	205.78	38.12
Health Net Community Solutions, Inc.	Kern	350.94	54.16
Health Net Community Solutions, Inc.	Los Angeles	274.97	35.29
Health Net Community Solutions, Inc.	Sacramento	305.99	44.04
Health Net Community Solutions, Inc.	San Diego	354.48	46.66
Health Net Community Solutions, Inc.	San Joaquin	266.70	53.47
Health Net Community Solutions, Inc.	Stanislaus	392.65	62.40
Health Net Community Solutions, Inc.	Tulare	505.10	42.27
Health Plan of San Joaquin	San Joaquin	249.11	45.89
Health Plan of San Joaquin	Stanislaus	272.99	56.07
Health Plan of San Mateo	San Mateo	445.65	48.80
Inland Empire Health Plan	San Bernardino/Riverside	288.05	48.50
Kaiser North	Sacramento	370.32	48.07
Kaiser South	San Diego	406.16	30.39
Kern Family Health Care	Kern	263.68	50.26
L.A. Care Health Plan	Los Angeles	310.27	35.61
Molina Healthcare of California Partner Plan, Inc.	Riverside/San Bernardino	206.96	39.94
Molina Healthcare of California Partner Plan, Inc.	Sacramento	257.68	50.20
Molina Healthcare of California Partner Plan, Inc.	San Diego	228.23	40.54
Partnership HealthPlan	Marin	342.84	43.50
Partnership HealthPlan	Mendocino	308.59	56.02
Partnership HealthPlan	Napa/Solano/Yolo	311.38	53.57
Partnership HealthPlan	Sonoma	354.14	39.40
San Francisco Health Plan	San Francisco	383.10	33.03
Santa Clara Family Health Plan	Santa Clara	260.02	32.64

8. SENIORS AND PERSONS WITH DISABILITIES POPULATION

In addition to reporting the External Accountability Set (EAS) in 2014, full-scope MCPs were required to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of measures. For the *Comprehensive Diabetes Care* hybrid measures, the MCPs were required to use an approved sampling methodology that yielded a valid sample for the SPD and non-SPD populations. The approved sampling methodology is in Appendix A. MCPs reported the rates for the SPD population separately via a Microsoft Excel reporting template. The SPD rates were compared to the non-SPD rates to identify statistically significant differences between the two populations.

In addition to the comparison in this section of the report, Appendix C provides a comparison of 2013 SPD rates to the 2014 SPD rates, and Appendix D provides a comparison of the 2013 Non-SPD rates to the 2014 Non-SPD rates.

Performance Measure Results

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

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

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

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

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

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

All-Cause Readmissions

Summary of Results

The SPD population had significantly higher readmissions rates than the non-SPD population for 33 of the 46 reported rates, which represented lower performance. Zero MCPs demonstrated a statistically significant lower readmission rate for the SPD population when compared to the non-SPD population.

Comparison of 2014 SPD Rates to 2013 SPD Rates

The SPD rates for six MCP counties were significantly lower in 2014 when compared to 2013, representing better performance in 2014. The SPD rates for three MCP counties were significantly higher in 2014 when compared to 2013, representing lower performance in 2014:

- ◆ Alameda Alliance for Health—Alameda County
- ◆ CalViva Health—Fresno County
- ◆ Health Plan of San Mateo—San Mateo County

Comparison of 2014 Non-SPD rates to 2013 Non-SPD Rates

The non-SPD rates for two MCP counties were significantly lower in 2014 when compared to 2013, representing better performance in 2014:

- ◆ Health Plan of San Mateo—San Mateo County
- ◆ L.A. Care Health Plan—Los Angeles County

The non-SPD rates for two MCP counties were significantly higher in 2014 when compared to 2013, representing lower performance in 2014.

- ◆ Alameda Alliance for Health—Alameda County
- ◆ Kern Family Health Care—Kern County

**Table 8.1—Medi-Cal Managed Care All-Cause Readmissions (Non-HEDIS Measure)
SPD versus Non-SPD
HEDIS Reporting Year 2014**

MCP Name	County	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Alameda Alliance for Health	Alameda	13.64%	19.54%	▼	17.42%
Anthem Blue Cross Partnership Plan	Alameda	10.91%	19.74%	▼	18.16%
Anthem Blue Cross Partnership Plan	Contra Costa	S	19.78%	↔	17.30%
Anthem Blue Cross Partnership Plan	Fresno	10.68%	16.18%	▼	14.38%
Anthem Blue Cross Partnership Plan	Kings	S	S	↔	8.43%
Anthem Blue Cross Partnership Plan	Madera	S	S	↔	8.63%
Anthem Blue Cross Partnership Plan	Sacramento	8.70%	13.26%	▼	11.83%
Anthem Blue Cross Partnership Plan	San Francisco	S	17.38%	↔	16.67%
Anthem Blue Cross Partnership Plan	Santa Clara	6.88%	16.33%	▼	13.75%
Anthem Blue Cross Partnership Plan	Tulare	8.22%	12.83%	▼	10.59%
CalOptima	Orange	10.83%	16.83%	▼	15.22%
CalViva Health	Fresno	7.78%	15.39%	▼	13.10%
CalViva Health	Kings	S	8.57%	↔	7.92%
CalViva Health	Madera	S	16.36%	▼	13.40%
Care1st Partner Plan	San Diego	8.64%	16.90%	▼	15.57%
CenCal Health	San Luis Obispo	6.71%	14.96%	▼	12.28%
CenCal Health	Santa Barbara	7.29%	16.41%	▼	13.15%
Central California Alliance for Health	Merced	8.00%	15.78%	▼	12.78%
Central California Alliance for Health	Monterey/Santa Cruz	7.69%	13.89%	▼	11.58%
Community Health Group Partnership Plan	San Diego	10.38%	14.88%	▼	13.28%
Contra Costa Health Plan	Contra Costa	9.53%	14.13%	▼	12.95%
Gold Coast Health Plan	Ventura	9.53%	15.06%	▼	13.08%
Health Net Community Solutions, Inc.	Kern	9.35%	12.18%	↔	11.50%
Health Net Community Solutions, Inc.	Los Angeles	6.53%	13.40%	▼	11.64%
Health Net Community Solutions, Inc.	Sacramento	9.16%	13.70%	▼	12.69%
Health Net Community Solutions, Inc.	San Diego	7.87%	17.37%	▼	15.90%
Health Net Community Solutions, Inc.	San Joaquin	NA	25.00%	Not Comparable	18.60%
Health Net Community Solutions, Inc.	Stanislaus	S	13.24%	▼	10.97%
Health Net Community Solutions, Inc.	Tulare	9.62%	12.77%	↔	11.74%
Health Plan of San Joaquin	San Joaquin	6.86%	13.65%	▼	11.06%
Health Plan of San Joaquin	Stanislaus	8.67%	15.88%	▼	13.11%
Health Plan of San Mateo	San Mateo	11.52%	16.78%	▼	15.68%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name	County	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Inland Empire Health Plan	San Bernardino/Riverside	9.67%	17.37%	▼	14.73%
Kaiser North	Sacramento	12.14%	17.24%	↔	16.07%
Kaiser South	San Diego	11.46%	11.41%	↔	11.42%
Kern Family Health Care	Kern	11.62%	18.74%	▼	14.94%
L.A. Care Health Plan	Los Angeles	9.19%	18.44%	▼	15.50%
Molina Healthcare of California Partner Plan, Inc.	Riverside/San Bernardino	8.46%	16.27%	▼	14.03%
Molina Healthcare of California Partner Plan, Inc.	Sacramento	7.34%	15.39%	▼	13.71%
Molina Healthcare of California Partner Plan, Inc.	San Diego	8.52%	17.07%	▼	14.93%
Partnership HealthPlan of California	Marin	S	17.72%	↔	16.45%
Partnership HealthPlan of California	Mendocino	S	13.24%	↔	11.46%
Partnership HealthPlan of California	Napa/Solano/Yolo	7.48%	16.98%	▼	15.60%
Partnership HealthPlan of California	Sonoma	9.54%	14.00%	↔	12.79%
San Francisco Health Plan	San Francisco	5.69%	17.88%	▼	13.86%
Santa Clara Family Health	Santa Clara	8.29%	18.25%	▼	15.20%

Annual Monitoring for Patients on Persistent Medications

Summary of Results

Consistent with 2013, the SPD rates were significantly higher than the non-SPD rates for both the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Annual Monitoring for Patients on Persistent Medications—Diuretics* measures, representing better performance. For most MCP counties, HSAG was not able to calculate if there was a statistically significant difference between the SPD and non-SPD rates for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure because many MCP counties had an audit result of “NA” for one or both populations for this measure, meaning that although the MCP complied with all applicable specifications, it had a denominator less than 30 for the measure, resulting in the “NA” audit result.

Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs

Twenty-eight MCP counties had SPD rates that were significantly higher than the non-SPD rates in 2014. Health Net Community Solutions, Inc.—Kern County was the only MCP county with an SPD rate that was significantly lower than the non-SPD rate.

The SPD rates for 12 MCP counties improved significantly from 2013 to 2014, and no SPD rates declined significantly.

The non-SPD rates for 13 counties improved significantly from 2013 to 2014, and Care1st Partner Plan—San Diego County was the only MCP county with a non-SPD rate that declined significantly from 2013 to 2014.

Annual Monitoring for Patients on Persistent Medications—Digoxin

As indicated above, HSAG could not calculate if there was a statistically significant difference between the SPD and non-SPD rates for most MCP counties for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure. For MCP counties where a comparison could be made, only one MCP county, L.A. Care Health Plan—Los Angeles County, had an SPD rate that was significantly lower than the non-SPD rate, representing lower performance.

The SPD rate for San Francisco Health Plan—San Francisco County improved significantly from 2013 to 2014, and no SPD rates declined significantly.

The non-SPD rate for L.A. Care Health Plan—Los Angeles County improved significantly from 2013 to 2014, while the non-SPD rate for Inland Empire Health Plan—Riverside/San Bernardino counties declined significantly from 2013 to 2014.

Annual Monitoring for Patients on Persistent Medications—Diuretics

Twenty-nine MCP counties had SPD rates that were significantly higher than the non-SPD rates in 2014, representing better performance, and no MCP counties had SPD rates that were significantly lower than the non-SPD rates.

The SPD rates for 11 MCP counties improved significantly from 2013 to 2014, and the rate for Inland Empire Health Plan—Riverside/San Bernardino counties was the only MCP county SPD rate that declined significantly from 2013 to 2014.

The non-SPD rates for 11 counties improved significantly from 2013 to 2014, and no non-SPD rates declined significantly.

**Table 8.2—Medi-Cal Managed Care Annual Monitoring for Patients on Persistent Medications
SPD versus Non-SPD
HEDIS Reporting Year 2014**

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Alameda Alliance for Health—Alameda	ACE Inhibitors or ARBs	80.91%	84.69%	↑	83.78%
	Digoxin	NA	92.80%	Not Comparable	93.43%
	Diuretics	81.90%	85.18%	↑	84.34%
Anthem Blue Cross Partnership Plan—Alameda	ACE Inhibitors or ARBs	71.79%	83.77%	↑	81.73%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	70.77%	82.80%	↑	80.81%
Anthem Blue Cross Partnership Plan—Contra Costa	ACE Inhibitors or ARBs	76.47%	81.38%	↔	80.33%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	67.35%	78.77%	↔	75.90%
Anthem Blue Cross Partnership Plan—Fresno	ACE Inhibitors or ARBs	81.76%	83.57%	↔	82.80%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	78.59%	85.08%	↑	82.63%
Anthem Blue Cross Partnership Plan—Kings	ACE Inhibitors or ARBs	80.56%	82.43%	↔	81.64%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	68.66%	83.70%	↑	77.36%
Anthem Blue Cross Partnership Plan—Madera	ACE Inhibitors or ARBs	81.82%	86.18%	↔	84.36%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	68.42%	84.62%	↔	78.64%
Anthem Blue Cross Partnership Plan—Sacramento	ACE Inhibitors or ARBs	75.38%	82.21%	↑	80.33%
	Digoxin	NA	85.29%	Not Comparable	87.80%
	Diuretics	70.27%	83.72%	↑	80.50%
Anthem Blue Cross Partnership Plan—San Francisco	ACE Inhibitors or ARBs	82.42%	84.77%	↔	84.48%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	80.39%	84.60%	↔	84.19%
Anthem Blue Cross Partnership Plan—Santa Clara	ACE Inhibitors or ARBs	83.51%	89.63%	↑	87.64%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	79.27%	88.49%	↑	85.77%
Anthem Blue Cross Partnership Plan—Tulare	ACE Inhibitors or ARBs	84.20%	85.94%	↔	85.06%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	81.50%	87.12%	↑	84.53%
CalOptima—Orange	ACE Inhibitors or ARBs	86.11%	91.90%	↑	90.55%
	Digoxin	NA	90.06%	Not Comparable	89.69%
	Diuretics	83.73%	91.16%	↑	89.62%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
CalViva Health—Fresno	ACE Inhibitors or ARBs	83.64%	85.27%	↔	84.64%
	Digoxin	NA	82.26%	Not Comparable	80.77%
	Diuretics	81.23%	86.97%	↑	84.96%
CalViva Health—Kings	ACE Inhibitors or ARBs	81.71%	91.32%	↑	87.21%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	74.56%	92.14%	↑	84.25%
CalViva Health—Madera	ACE Inhibitors or ARBs	80.41%	85.77%	↔	83.06%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	81.42%	89.71%	↔	85.94%
Care1st Partner Plan—San Diego	ACE Inhibitors or ARBs	76.14%	85.13%	↑	83.72%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	72.65%	85.98%	↑	83.96%
CenCal Health—San Luis Obispo	ACE Inhibitors or ARBs	71.79%	83.97%	↑	80.16%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	72.97%	90.28%	↑	84.92%
CenCal Health—Santa Barbara	ACE Inhibitors or ARBs	79.54%	89.25%	↑	85.79%
	Digoxin	NA	83.33%	Not Comparable	84.85%
	Diuretics	81.53%	89.19%	↑	86.74%
Central California Alliance for Health—Merced	ACE Inhibitors or ARBs	82.92%	90.10%	↑	86.87%
	Digoxin	NA	NA	Not Comparable	83.33%
	Diuretics	79.91%	91.17%	↑	86.43%
Central California Alliance for Health—Monterey/Santa Cruz	ACE Inhibitors or ARBs	83.28%	89.63%	↑	87.34%
	Digoxin	NA	87.80%	Not Comparable	87.76%
	Diuretics	80.85%	90.06%	↑	87.02%
Community Health Group Partnership Plan—San Diego	ACE Inhibitors or ARBs	83.18%	89.03%	↑	87.41%
	Digoxin	NA	95.31%	Not Comparable	95.71%
	Diuretics	81.92%	90.33%	↑	88.16%
Contra Costa Health Plan—Contra Costa	ACE Inhibitors or ARBs	83.51%	87.41%	↑	86.52%
	Digoxin	NA	95.00%	Not Comparable	95.45%
	Diuretics	84.67%	85.24%	↔	85.11%
Gold Coast Health Plan—Ventura	ACE Inhibitors or ARBs	87.52%	89.11%	↔	88.47%
	Digoxin	NA	92.50%	Not Comparable	93.33%
	Diuretics	88.58%	90.10%	↔	89.51%
Health Net Community Solutions, Inc.—Kern	ACE Inhibitors or ARBs	86.73%	80.38%	↓	82.19%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	82.89%	81.49%	↔	81.82%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Health Net Community Solutions, Inc.—Los Angeles	ACE Inhibitors or ARBs	77.70%	81.62%	↑	80.35%
	Digoxin	80.00%	87.45%	↔	86.38%
	Diuretics	76.55%	82.59%	↑	80.78%
Health Net Community Solutions, Inc.—Sacramento	ACE Inhibitors or ARBs	67.61%	74.02%	↑	72.60%
	Digoxin	NA	84.75%	Not Comparable	84.75%
	Diuretics	63.48%	72.64%	↑	70.56%
Health Net Community Solutions, Inc.—San Diego	ACE Inhibitors or ARBs	83.47%	90.18%	↑	89.08%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	78.26%	90.62%	↑	88.33%
Health Net Community Solutions, Inc.—San Joaquin	ACE Inhibitors or ARBs	57.45%	75.47%	↔	67.00%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	NA	NA	Not Comparable	65.45%
Health Net Community Solutions, Inc.—Stanislaus	ACE Inhibitors or ARBs	81.05%	84.15%	↔	83.17%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	79.47%	86.17%	↑	84.38%
Health Net Community Solutions, Inc.—Tulare	ACE Inhibitors or ARBs	85.29%	84.40%	↔	84.77%
	Digoxin	NA	90.00%	Not Comparable	91.43%
	Diuretics	81.40%	85.63%	↔	84.10%
Health Plan of San Joaquin—San Joaquin	ACE Inhibitors or ARBs	81.28%	85.07%	↑	83.80%
	Digoxin	NA	93.18%	Not Comparable	94.12%
	Diuretics	80.14%	86.24%	↑	84.29%
Health Plan of San Joaquin—Stanislaus	ACE Inhibitors or ARBs	80.48%	87.72%	↑	84.64%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	84.05%	89.27%	↔	87.39%
Health Plan of San Mateo—San Mateo	ACE Inhibitors or ARBs	83.57%	91.58%	↑	90.97%
	Digoxin	NA	94.84%	Not Comparable	94.34%
	Diuretics	82.05%	92.65%	↑	91.85%
Inland Empire Health Plan—Riverside/San Bernardino	ACE Inhibitors or ARBs	82.43%	88.35%	↑	86.33%
	Digoxin	85.19%	91.64%	↔	90.80%
	Diuretics	80.92%	87.55%	↑	85.42%
Kaiser North—Sacramento	ACE Inhibitors or ARBs	93.08%	96.00%	↑	95.24%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	91.16%	96.55%	↑	95.09%
Kaiser South—San Diego	ACE Inhibitors or ARBs	90.99%	96.68%	↑	93.76%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	91.03%	96.13%	↔	93.57%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Kern Family Health Care—Kern	ACE Inhibitors or ARBs	88.05%	90.14%	↔	88.95%
	Digoxin	NA	93.33%	Not Comparable	93.48%
	Diuretics	88.03%	91.41%	↑	89.62%
L.A. Care Health Plan—Los Angeles	ACE Inhibitors or ARBs	78.24%	79.22%	↑	78.93%
	Digoxin	89.77%	79.65%	↓	80.72%
	Diuretics	77.33%	78.52%	↔	78.17%
Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino	ACE Inhibitors or ARBs	83.84%	89.83%	↑	87.83%
	Digoxin	NA	95.00%	Not Comparable	95.56%
	Diuretics	81.00%	89.26%	↑	86.60%
Molina Healthcare of California Partner Plan, Inc.—Sacramento	ACE Inhibitors or ARBs	77.06%	80.05%	↔	79.52%
	Digoxin	NA	83.87%	Not Comparable	82.86%
	Diuretics	75.81%	80.25%	↔	79.48%
Molina Healthcare of California Partner Plan, Inc.—San Diego	ACE Inhibitors or ARBs	81.81%	87.49%	↑	86.03%
	Digoxin	NA	80.36%	Not Comparable	79.66%
	Diuretics	82.50%	88.57%	↑	87.07%
Partnership HealthPlan of California—Marin	ACE Inhibitors or ARBs	82.76%	85.42%	↔	84.90%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	84.09%	88.65%	↔	87.77%
Partnership HealthPlan of California—Mendocino	ACE Inhibitors or ARBs	80.58%	83.17%	↔	82.37%
	Digoxin	NA	NA	Not Comparable	NA
	Diuretics	78.46%	81.52%	↔	80.80%
Partnership HealthPlan of California—Napa/Solano/Yolo	ACE Inhibitors or ARBs	84.91%	90.49%	↑	89.71%
	Digoxin	NA	94.90%	Not Comparable	94.44%
	Diuretics	83.24%	90.39%	↑	89.42%
Partnership HealthPlan of California—Sonoma	ACE Inhibitors or ARBs	80.70%	85.94%	↑	84.41%
	Digoxin	NA	87.88%	Not Comparable	88.89%
	Diuretics	81.87%	86.11%	↔	85.05%
San Francisco Health Plan—San Francisco	ACE Inhibitors or ARBs	86.25%	87.62%	↔	87.32%
	Digoxin	NA	95.12%	Not Comparable	95.92%
	Diuretics	83.72%	86.98%	↔	86.31%
Santa Clara Family Health—Santa Clara	ACE Inhibitors or ARBs	82.83%	89.10%	↑	87.39%
	Digoxin	NA	88.61%	Not Comparable	89.01%
	Diuretics	81.68%	90.26%	↑	87.91%

Children and Adolescents' Access to Primary Care Practitioners

Summary of Results

Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months

No MCP counties had SPD rates that were significantly higher than the non-SPD rates in 2014. The SPD rates for the following MCP counties were significantly lower than the non-SPD rates, demonstrating lower performance:

- ◆ CalOptima—Orange County
- ◆ Gold Coast Health Plan—Ventura County
- ◆ Health Net Community Solutions, Inc.—Los Angeles County
- ◆ L.A. Care Health Plan—Los Angeles County
- ◆ Santa Clara Family Health Plan—Santa Clara County

The SPD rates for the following MCP counties improved significantly from 2013 to 2014:

- ◆ Alameda Alliance for Health—Alameda County
- ◆ CalViva Health—Fresno County

The SPD rates for the following MCP counties declined significantly from 2013 to 2014:

- ◆ Health Net Community Solutions, Inc.—Los Angeles County
- ◆ Santa Clara Family Health Plan—Santa Clara County

The non-SPD rates for eight MCP counties improved significantly from 2013 to 2014, and the non-SPD rates for the following MCP counties declined significantly from 2013 to 2014:

- ◆ CalViva Health—Fresno County
- ◆ Care1st Partner Plan—San Diego County
- ◆ Community Health Group Partnership Plan—San Diego County
- ◆ Health Net Community Solutions, Inc.—Stanislaus County

Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years

The SPD rates for the following MCP counties were significantly higher than the non-SPD rates in 2014, demonstrating better performance:

- ◆ Central California Alliance for Health—Monterey/Santa Cruz counties
- ◆ Kaiser North—Sacramento County

Twelve MCP counties had SPD rates that were significantly lower than the non-SPD rates in 2014.

The SPD rates for the following MCP counties improved significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—Alameda County
- ◆ Contra Costa Health Plan—Contra Costa County
- ◆ Gold Coast Health Plan—Ventura County

The SPD rates for the following MCP counties declined significantly from 2013 to 2014:

- ◆ Health Net Community Solutions, Inc.—Tulare County
- ◆ Health Plan of San Joaquin—San Joaquin County

The non-SPD rates for 22 MCP counties improved significantly from 2013 to 2014, and the rates for the following five MCP counties declined significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—Alameda County
- ◆ Cal Viva Health—Fresno County and Kings County
- ◆ Health Net Community Solutions, Inc.—Stanislaus County
- ◆ Kaiser North—Sacramento County

Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years

The SPD rates for six MCP counties were significantly higher than the non-SPD rates in 2014, demonstrating better performance, and nine MCP counties had SPD rates that were significantly lower than the non-SPD rates in 2014.

No SPD rates improved significantly from 2013 to 2014, and the SPD rates for five MCP counties declined significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—San Francisco County
- ◆ Care1st Partner Plan—San Diego County
- ◆ Community Health Group Partnership Plan—San Diego County
- ◆ Health Net Community Solutions, Inc.—Los Angeles County
- ◆ L.A. Care Health Plan—Los Angeles County

Eighteen non-SPD rates improved significantly from 2013 to 2014, and the non-SPD rates for the following MCP counties declined significantly from 2013 to 2014:

- ◆ Health Net Community Solutions, Inc.—Los Angeles County

- ◆ Kaiser North—Sacramento County
- ◆ Kaiser South—San Diego County
- ◆ L.A. Care Health Plan—Los Angeles County

Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years

The SPD rates for the following MCP counties were significantly higher than the non-SPD rates in 2014, demonstrating better performance:

- ◆ Health Plan of San Joaquin—San Joaquin County
- ◆ Kaiser North—Sacramento County
- ◆ Kaiser South—San Diego County

Eighteen MCP counties had SPD rates that were significantly lower than the non-SPD rates in 2014.

No SPD rates improved significantly from 2013 to 2014, and the SPD rates for eight MCP counties declined significantly from 2013 to 2014.

The non-SPD rates for the following five MCP counties improved significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—Fresno County and Tulare County
- ◆ Cen Cal Health—Santa Barbara County
- ◆ Contra Costa Health Plan—Contra Costa County
- ◆ Molina Healthcare of California Partner Plan, Inc.—San Diego County

The non-SPD rates for 20 MCP counties declined significantly from 2013 to 2014.

**Table 8.3—Medi-Cal Managed Care Children and Adolescents' Access to Primary Care Practitioners
SPD versus Non-SPD
HEDIS Reporting Year 2014**

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Alameda Alliance for Health—Alameda	12 to 24 months	94.25%	100.0%	↔	94.34%
	25 months to 6 years	85.07%	86.01%	↔	85.10%
	7 to 11 years	87.03%	87.57%	↔	87.07%
	12 to 19 years	83.59%	79.65%	↓	83.24%
Anthem Blue Cross Partnership Plan—Alameda	12 to 24 months	85.30%	NA	Not Comparable	85.16%
	25 months to 6 years	77.79%	78.70%	↔	77.82%
	7 to 11 years	78.54%	79.11%	↔	78.58%
	12 to 19 years	75.79%	70.43%	↓	75.18%
Anthem Blue Cross Partnership Plan—Contra Costa	12 to 24 months	95.23%	NA	Not Comparable	95.12%
	25 months to 6 years	86.31%	89.36%	↔	86.44%
	7 to 11 years	88.35%	87.61%	↔	88.29%
	12 to 19 years	85.16%	83.50%	↔	84.96%
Anthem Blue Cross Partnership Plan—Fresno	12 to 24 months	93.86%	NA	Not Comparable	93.76%
	25 months to 6 years	83.33%	84.85%	↔	83.38%
	7 to 11 years	83.46%	84.70%	↔	83.51%
	12 to 19 years	79.14%	79.00%	↔	79.14%
Anthem Blue Cross Partnership Plan—Kings	12 to 24 months	94.71%	NA	Not Comparable	94.74%
	25 months to 6 years	83.36%	80.00%	↔	83.25%
	7 to 11 years	84.26%	95.92%	↑	84.78%
	12 to 19 years	84.62%	84.93%	↔	84.64%
Anthem Blue Cross Partnership Plan—Madera	12 to 24 months	98.45%	NA	Not Comparable	98.47%
	25 months to 6 years	90.87%	93.62%	↔	90.94%
	7 to 11 years	90.58%	97.44%	↔	90.80%
	12 to 19 years	88.52%	92.86%	↔	88.72%
Anthem Blue Cross Partnership Plan—Sacramento	12 to 24 months	94.06%	92.31%	↔	94.03%
	25 months to 6 years	81.70%	78.10%	↓	81.58%
	7 to 11 years	80.76%	83.31%	↔	80.92%
	12 to 19 years	78.05%	79.13%	↔	78.14%
Anthem Blue Cross Partnership Plan—San Francisco	12 to 24 months	96.95%	NA	Not Comparable	96.63%
	25 months to 6 years	89.53%	70.97%	↓	89.05%
	7 to 11 years	89.73%	77.50%	↓	89.23%
	12 to 19 years	88.40%	88.35%	↔	88.40%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Anthem Blue Cross Partnership Plan—Santa Clara	12 to 24 months	95.97%	NA	Not Comparable	95.43%
	25 months to 6 years	87.66%	81.45%	↓	87.49%
	7 to 11 years	89.89%	86.89%	↔	89.72%
	12 to 19 years	85.77%	83.11%	↔	85.64%
Anthem Blue Cross Partnership Plan—Tulare	12 to 24 months	97.77%	NA	Not Comparable	97.75%
	25 months to 6 years	90.38%	89.09%	↔	90.35%
	7 to 11 years	88.28%	86.57%	↔	88.21%
	12 to 19 years	87.56%	86.76%	↔	87.52%
CalOptima—Orange	12 to 24 months	97.54%	85.27%	↓	97.42%
	25 months to 6 years	91.62%	85.47%	↓	91.43%
	7 to 11 years	92.64%	85.84%	↓	92.30%
	12 to 19 years	89.52%	80.71%	↓	89.07%
CalViva Health—Fresno	12 to 24 months	96.57%	100.0%	↔	96.60%
	25 months to 6 years	91.06%	91.65%	↔	91.08%
	7 to 11 years	91.33%	93.33%	↑	91.42%
	12 to 19 years	87.45%	88.51%	↔	87.51%
CalViva Health—Kings	12 to 24 months	94.85%	NA	Not Comparable	94.68%
	25 months to 6 years	83.44%	87.65%	↔	83.58%
	7 to 11 years	86.92%	90.00%	↔	87.06%
	12 to 19 years	84.55%	85.71%	↔	84.62%
CalViva Health—Madera	12 to 24 months	98.06%	NA	Not Comparable	98.08%
	25 months to 6 years	93.38%	97.17%	↔	93.49%
	7 to 11 years	92.84%	94.29%	↔	92.88%
	12 to 19 years	90.76%	88.42%	↔	90.68%
Care1st Partner Plan—San Diego	12 to 24 months	89.78%	NA	Not Comparable	89.27%
	25 months to 6 years	81.31%	69.03%	↓	80.91%
	7 to 11 years	81.93%	62.64%	↓	80.88%
	12 to 19 years	79.34%	70.67%	↓	78.71%
CenCal Health—San Luis Obispo	12 to 24 months	96.86%	NA	Not Comparable	96.78%
	25 months to 6 years	90.04%	76.07%	↓	89.60%
	7 to 11 years	90.91%	83.22%	↓	90.47%
	12 to 19 years	87.41%	79.72%	↓	86.83%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
CenCal Health—Santa Barbara	12 to 24 months	98.48%	NA	Not Comparable	98.49%
	25 months to 6 years	93.63%	90.99%	↔	93.58%
	7 to 11 years	92.99%	90.32%	↔	92.88%
	12 to 19 years	90.65%	89.52%	↔	90.59%
Central California Alliance for Health—Merced	12 to 24 months	97.66%	NA	Not Comparable	97.63%
	25 months to 6 years	91.67%	91.03%	↔	91.65%
	7 to 11 years	90.11%	94.07%	↑	90.31%
	12 to 19 years	88.58%	86.86%	↔	88.46%
Central California Alliance for Health—Monterey/Santa Cruz	12 to 24 months	98.32%	NA	Not Comparable	98.31%
	25 months to 6 years	92.06%	95.29%	↑	92.11%
	7 to 11 years	93.21%	92.34%	↔	93.18%
	12 to 19 years	91.08%	87.52%	↓	90.94%
Community Health Group Partnership Plan—San Diego	12 to 24 months	95.94%	97.37%	↔	95.95%
	25 months to 6 years	89.97%	88.30%	↔	89.92%
	7 to 11 years	89.39%	89.97%	↔	89.41%
	12 to 19 years	85.50%	84.81%	↔	85.47%
Contra Costa Health Plan—Contra Costa	12 to 24 months	94.62%	NA	Not Comparable	94.62%
	25 months to 6 years	86.03%	87.47%	↔	86.07%
	7 to 11 years	86.72%	86.49%	↔	86.71%
	12 to 19 years	83.50%	82.72%	↔	83.44%
Gold Coast Health Plan—Ventura	12 to 24 months	97.46%	89.74%	↓	97.37%
	25 months to 6 years	86.35%	83.61%	↔	86.27%
	7 to 11 years	82.53%	77.69%	↓	82.26%
	12 to 19 years	79.68%	72.72%	↓	79.18%
Health Net Community Solutions, Inc.—Kern	12 to 24 months	93.14%	NA	Not Comparable	92.95%
	25 months to 6 years	79.32%	73.87%	↔	79.16%
	7 to 11 years	67.84%	70.16%	↔	67.96%
	12 to 19 years	67.83%	63.26%	↔	67.50%
Health Net Community Solutions, Inc.—Los Angeles	12 to 24 months	94.70%	73.01%	↓	94.47%
	25 months to 6 years	81.27%	78.05%	↓	81.18%
	7 to 11 years	82.04%	81.11%	↔	81.99%
	12 to 19 years	77.67%	73.04%	↓	77.41%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Health Net Community Solutions, Inc.—Sacramento	12 to 24 months	92.50%	97.22%	↔	92.57%
	25 months to 6 years	81.11%	79.88%	↔	81.06%
	7 to 11 years	79.18%	83.38%	↔	79.43%
	12 to 19 years	75.14%	73.71%	↔	75.02%
Health Net Community Solutions, Inc.—San Diego	12 to 24 months	96.17%	NA	Not Comparable	95.87%
	25 months to 6 years	88.28%	75.61%	↓	87.67%
	7 to 11 years	86.55%	81.54%	↔	86.20%
	12 to 19 years	82.56%	77.03%	↓	82.09%
Health Net Community Solutions, Inc.—San Joaquin	12 to 24 months	91.89%	NA	Not Comparable	92.11%
	25 months to 6 years	76.48%	NA	Not Comparable	76.97%
	7 to 11 years	NA	NA	Not Comparable	NA
	12 to 19 years	NA	NA	Not Comparable	NA
Health Net Community Solutions, Inc.—Stanislaus	12 to 24 months	95.53%	NA	Not Comparable	95.59%
	25 months to 6 years	85.74%	86.32%	↔	85.89%
	7 to 11 years	86.32%	87.57%	↔	86.39%
	12 to 19 years	83.89%	83.08%	↔	83.84%
Health Net Community Solutions, Inc.—Tulare	12 to 24 months	97.57%	NA	Not Comparable	97.60%
	25 months to 6 years	92.05%	90.20%	↔	91.99%
	7 to 11 years	91.06%	94.23%	↔	91.23%
	12 to 19 years	89.35%	90.40%	↔	89.42%
Health Plan of San Joaquin—San Joaquin	12 to 24 months	97.00%	100.0%	↔	97.04%
	25 months to 6 years	87.86%	86.09%	↔	87.79%
	7 to 11 years	86.67%	87.37%	↔	86.70%
	12 to 19 years	83.07%	85.91%	↑	83.23%
Health Plan of San Joaquin—Stanislaus	12 to 24 months	97.21%	NA	Not Comparable	97.23%
	25 months to 6 years	88.33%	93.20%	↔	88.43%
	7 to 11 years	88.87%	NA	Not Comparable	88.90%
	12 to 19 years	86.62%	NA	Not Comparable	86.60%
Health Plan of San Mateo—San Mateo	12 to 24 months	97.15%	NA	Not Comparable	97.13%
	25 months to 6 years	90.80%	77.57%	↓	90.40%
	7 to 11 years	90.92%	72.88%	↓	89.74%
	12 to 19 years	86.89%	68.15%	↓	85.34%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Inland Empire Health Plan—Riverside/San Bernardino	12 to 24 months	96.70%	94.61%	↔	96.67%
	25 months to 6 years	86.81%	85.58%	↔	86.77%
	7 to 11 years	84.46%	86.46%	↑	84.55%
	12 to 19 years	84.06%	82.45%	↓	83.97%
Kaiser North—Sacramento	12 to 24 months	99.48%	NA	Not Comparable	99.48%
	25 months to 6 years	88.06%	93.75%	↑	88.25%
	7 to 11 years	83.92%	96.33%	↑	84.70%
	12 to 19 years	85.09%	93.19%	↑	85.87%
Kaiser South—San Diego	12 to 24 months	99.50%	NA	Not Comparable	99.51%
	25 months to 6 years	93.49%	98.80%	↔	93.60%
	7 to 11 years	89.42%	99.08%	↑	89.97%
	12 to 19 years	87.65%	96.32%	↑	88.17%
Kern Family Health Care—Kern	12 to 24 months	93.25%	92.59%	↔	93.24%
	25 months to 6 years	84.37%	84.46%	↔	84.37%
	7 to 11 years	81.42%	79.50%	↔	81.39%
	12 to 19 years	80.64%	78.43%	↔	80.60%
L.A. Care Health Plan—Los Angeles	12 to 24 months	91.98%	79.34%	↓	91.83%
	25 months to 6 years	82.88%	81.02%	↓	82.82%
	7 to 11 years	83.93%	83.01%	↓	83.89%
	12 to 19 years	79.56%	77.77%	↓	79.45%
Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino	12 to 24 months	92.80%	NA	Not Comparable	92.67%
	25 months to 6 years	85.22%	78.45%	↓	85.02%
	7 to 11 years	85.22%	83.40%	↔	85.15%
	12 to 19 years	84.03%	76.02%	↓	83.63%
Molina Healthcare of California Partner Plan, Inc.—Sacramento	12 to 24 months	94.72%	NA	Not Comparable	94.51%
	25 months to 6 years	83.98%	80.95%	↔	83.89%
	7 to 11 years	83.01%	79.07%	↔	82.85%
	12 to 19 years	81.09%	74.85%	↓	80.58%
Molina Healthcare of California Partner Plan, Inc.—San Diego	12 to 24 months	95.85%	NA	Not Comparable	95.73%
	25 months to 6 years	88.86%	86.83%	↔	88.81%
	7 to 11 years	89.22%	84.92%	↓	89.06%
	12 to 19 years	86.40%	81.87%	↓	86.20%
Partnership HealthPlan of California—Marin	12 to 24 months	99.10%	NA	Not Comparable	99.10%
	25 months to 6 years	90.78%	83.93%	↔	90.64%
	7 to 11 years	87.41%	84.15%	↔	87.25%
	12 to 19 years	85.57%	68.29%	↓	84.18%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Partnership HealthPlan of California—Mendocino	12 to 24 months	95.78%	NA	Not Comparable	95.80%
	25 months to 6 years	88.55%	92.98%	↔	88.64%
	7 to 11 years	88.58%	87.01%	↔	88.51%
	12 to 19 years	88.52%	85.82%	↔	88.35%
Partnership HealthPlan of California—Napa/Solano/Yolo	12 to 24 months	96.88%	92.31%	↔	96.81%
	25 months to 6 years	87.88%	85.68%	↔	87.79%
	7 to 11 years	85.88%	85.27%	↔	85.84%
	12 to 19 years	84.15%	81.25%	↓	83.80%
Partnership HealthPlan of California—Sonoma	12 to 24 months	98.27%	NA	Not Comparable	98.23%
	25 months to 6 years	90.28%	91.75%	↔	90.32%
	7 to 11 years	87.13%	89.15%	↔	87.25%
	12 to 19 years	86.68%	87.34%	↔	86.73%
San Francisco Health Plan—San Francisco	12 to 24 months	97.04%	NA	Not Comparable	97.01%
	25 months to 6 years	92.69%	83.33%	↓	92.55%
	7 to 11 years	94.85%	89.41%	↓	94.70%
	12 to 19 years	91.16%	86.96%	↓	91.04%
Santa Clara Family Health—Santa Clara	12 to 24 months	97.31%	80.95%	↓	97.15%
	25 months to 6 years	88.94%	88.93%	↔	88.94%
	7 to 11 years	90.52%	88.55%	↔	90.46%
	12 to 19 years	87.49%	86.53%	↔	87.46%

Comprehensive Diabetes Care

Summary of Results

With the exception of the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure, overall, the SPD rates were better than the non-SPD rates for the *Comprehensive Diabetes Care* measures, which is consistent with 2013. The better rates for the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. The statistically significant differences from 2013 to 2014 for the SPD rates and non-SPD rates for the *Comprehensive Diabetes Care* measures are summarized below:

Blood Pressure Control (<140/90 mm Hg)

The SPD rates for Kaiser South—San Diego County and Partnership HealthPlan of California—Mendocino County improved significantly from 2013 to 2014, and the SPD rates for 11 MCP counties declined significantly from 2013 to 2014.

The non-SPD rates for Health Net Community Solutions, Inc.—Los Angeles County and Health Plan of San Mateo—San Mateo County improved significantly from 2013 to 2014, and the non-SPD rates for nine MCP counties declined significantly from 2013 to 2014.

Eye Exam (Retinal) Performed

The SPD rates for the following four MCP counties improved significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—Sacramento County and Tulare County
- ◆ CalViva Health—Kings County
- ◆ Partnership HealthPlan of California—Napa/Solano/Yolo counties

The SPD rates for the following MCP counties declined significantly from 2013 to 2014:

- ◆ Alameda Alliance for Health—Alameda County
- ◆ Anthem Blue Cross Partnership Plan—Santa Clara County
- ◆ Cal Optima—Orange County

The non-SPD rates for the following MCP counties improved significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—San Francisco County
- ◆ CalViva Health—Madera County
- ◆ CenCal Health—San Luis Obispo County

- ◆ Health Plan of San Mateo—San Mateo County
- ◆ Santa Clara Family Health Plan—Santa Clara County

Only one non-SPD rate declined significantly from 2013 to 2014: Central California Alliance for Health—Monterey/Santa Cruz counties.

HbA1c Testing

The SPD rates for the following MCP counties improved significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—Alameda County
- ◆ CalViva Health—Kings County
- ◆ Health Net Community Solutions, Inc.—Kern County
- ◆ Health Plan of San Mateo—San Mateo County

The SPD rates for following four MCP counties declined significantly from 2013 to 2014:

- ◆ Health Net Community Solutions, Inc.—San Diego County and Tulare County
- ◆ Partnership HealthPlan of California—Mendocino County and Sonoma County

The non-SPD rates for the following five MCP counties improved significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—Alameda County and Fresno County
- ◆ CalViva Health—Kings County
- ◆ CenCal Health—San Luis Obispo County
- ◆ Health Net Community Solutions, Inc.—Kern County

The non-SPD rates for the following five MCP counties declined significantly from 2013 to 2014:

- ◆ Alameda Alliance for Health—Alameda County
- ◆ Health Net Community Solutions, Inc.—San Diego County and Tulare County
- ◆ Partnership HealthPlan of California—Mendocino County and Napa/Solano/Yolo counties

HbA1c Control (<8.0 Percent)

The SPD rate for Gold Coast Health Plan—Ventura County improved significantly from 2013 to 2014, and the SPD rates for 11 MCP counties declined significantly from 2013 to 2014.

The non-SPD rate for Gold Coast Health Plan—Ventura County improved significantly from 2013 to 2014, and the non-SPD rates for seven MCP counties declined significantly from 2013 to 2014.

LDL-C Control (<100 mg/dL)

The SPD rate for Health Plan of San Joaquin—San Joaquin County improved significantly from 2013 to 2014, and the SPD rates for the following five MCP counties declined significantly from 2013 to 2014:

- ◆ Alameda Alliance for Health—Alameda County
- ◆ Anthem Blue Cross Partnership Plan—Fresno County, San Francisco County, and Tulare County
- ◆ Health Net Community Solutions, Inc.—San Diego County

The non-SPD rates for the following MCP counties improved significantly from 2013 to 2014:

- ◆ CalOptima—Orange County
- ◆ CalViva Health—Kings County
- ◆ L.A. Care Health Plan—Los Angeles County

The non-SPD rates for six MCP counties declined significantly from 2013 to 2014.

LDL-C Screening

The SPD rates for the following MCP counties improved significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—Alameda County
- ◆ CalViva Health—Kings County
- ◆ Central California Alliance for Health—Monterey/Santa Cruz counties
- ◆ Molina Healthcare of California Partner Plan, Inc.—Sacramento County

The SPD rates for six MCP counties declined significantly from 2013 to 2014.

The non-SPD rates for Anthem Blue Cross Partnership Plan—Fresno County and CalViva Health—Kings County improved significantly from 2013 to 2014, and the non-SPD rates for the following MCP counties declined significantly from 2013 to 2014:

- ◆ Alameda Alliance for Health—Alameda County
- ◆ Central California Alliance for Health—Monterey/Santa Cruz counties
- ◆ Contra Costa Health Plan—Contra Costa County
- ◆ Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino counties
- ◆ Partnership HealthPlan of California—Mendocino County

Medical Attention for Nephropathy

The SPD rates for Health Plan of San Mateo—San Mateo County and L.A. Care Health Plan—Los Angeles County improved significantly from 2013 to 2014 and the SPD rates for Care1st Partner Plan—San Diego County and Health Net Community Solutions, Inc.—San Diego County declined significantly from 2013 to 2014.

The non-SPD rates for the following four MCP counties improved significantly from 2013 to 2014:

- ◆ Anthem Blue Cross Partnership Plan—Contra Costa County and Sacramento County
- ◆ CenCal Health—San Luis Obispo County
- ◆ Health Plan of San Mateo—San Mateo County

The non-SPD rates for the following counties declined significantly from 2013 to 2014:

- ◆ Alameda Alliance for Health—Alameda County
- ◆ Community Health Group Partnership Plan—San Diego County
- ◆ Health Net Community Solutions, Inc.—Tulare County
- ◆ Health Plan of San Joaquin—San Joaquin County
- ◆ Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino counties

HbA1c Poor Control (>9.0 Percent)

The SPD rates for the following MCP counties were significantly lower in 2014 when compared to 2013, representing better performance in 2014:

- ◆ Gold Coast Health Plan—Ventura County
- ◆ Health Net Community Solutions, Inc.—San Joaquin County
- ◆ Health Plan of San Joaquin—San Joaquin County
- ◆ Health Plan of San Mateo—San Mateo County

The SPD rates for 11 MCP counties were significantly higher in 2014 when compared to 2013, representing lower performance.

The non-SPD rates for CenCal Health—San Luis Obispo County and Gold Coast Health Plan—Ventura County were significantly lower in 2014 when compared to 2013, representing better performance in 2014; and the non-SPD rates for 10 MCP counties were significantly higher in 2014 when compared to 2013, representing lower performance.

**Table 8.4—Medi-Cal Managed Care Comprehensive Diabetes Care
SPD versus Non-SPD
HEDIS Reporting Year 2014**

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Alameda Alliance for Health—Alameda	Blood Pressure Control (<140/90 mm Hg)	61.63%	56.93%	↔	57.66%
	Eye Exam (Retinal) Performed	44.06%	43.55%	↔	45.26%
	HbA1c Testing	77.48%	84.43%	↑	81.75%
	HbA1c Control (<8.0 Percent)	44.80%	54.74%	↑	48.18%
	LDL-C Control (<100 mg/dL)	28.47%	30.90%	↔	29.20%
	LDL-C Screening	63.86%	78.10%	↑	71.29%
	Medical Attention for Nephropathy	73.76%	85.16%	↑	80.05%
	HbA1c Poor Control (>9.0 Percent)	55.20%	45.26%	▲	51.82%
Anthem Blue Cross Partnership Plan—Alameda	Blood Pressure Control (<140/90 mm Hg)	46.33%	38.72%	↓	38.41%
	Eye Exam (Retinal) Performed	36.68%	34.96%	↔	35.10%
	HbA1c Testing	73.36%	77.88%	↔	75.94%
	HbA1c Control (<8.0 Percent)	27.41%	27.88%	↔	26.05%
	LDL-C Control (<100 mg/dL)	15.06%	19.91%	↔	17.66%
	LDL-C Screening	55.60%	66.81%	↑	61.37%
	Medical Attention for Nephropathy	66.02%	78.32%	↑	73.95%
	HbA1c Poor Control (>9.0 Percent)	66.41%	66.15%	↔	67.55%
Anthem Blue Cross Partnership Plan—Contra Costa	Blood Pressure Control (<140/90 mm Hg)	48.96%	44.57%	↔	46.13%
	Eye Exam (Retinal) Performed	40.63%	36.00%	↔	37.64%
	HbA1c Testing	72.92%	76.57%	↔	75.28%
	HbA1c Control (<8.0 Percent)	40.63%	33.71%	↔	36.16%
	LDL-C Control (<100 mg/dL)	21.88%	33.71%	↑	29.52%
	LDL-C Screening	62.50%	69.71%	↔	67.16%
	Medical Attention for Nephropathy	68.75%	84.00%	↑	78.60%
	HbA1c Poor Control (>9.0 Percent)	54.17%	58.29%	↔	56.83%
Anthem Blue Cross Partnership Plan—Fresno	Blood Pressure Control (<140/90 mm Hg)	54.57%	50.88%	↔	52.44%
	Eye Exam (Retinal) Performed	42.09%	39.82%	↔	44.89%
	HbA1c Testing	79.29%	78.98%	↔	79.33%
	HbA1c Control (<8.0 Percent)	33.85%	33.63%	↔	36.22%
	LDL-C Control (<100 mg/dL)	29.84%	28.54%	↔	30.89%
	LDL-C Screening	73.27%	74.56%	↔	74.89%
	Medical Attention for Nephropathy	75.95%	80.75%	↔	80.22%
	HbA1c Poor Control (>9.0 Percent)	54.12%	51.55%	↔	50.00%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Anthem Blue Cross Partnership Plan—Kings	Blood Pressure Control (<140/90 mm Hg)	60.74%	48.60%	↓	54.39%
	Eye Exam (Retinal) Performed	38.04%	42.46%	↔	40.35%
	HbA1c Testing	72.39%	72.63%	↔	72.51%
	HbA1c Control (<8.0 Percent)	23.31%	27.93%	↔	25.73%
	LDL-C Control (<100 mg/dL)	14.72%	24.02%	↑	19.59%
	LDL-C Screening	67.48%	69.27%	↔	68.42%
	Medical Attention for Nephropathy	73.62%	80.45%	↔	77.19%
	HbA1c Poor Control (>9.0 Percent)	65.03%	64.80%	↔	64.91%
Anthem Blue Cross Partnership Plan—Madera	Blood Pressure Control (<140/90 mm Hg)	59.06%	62.84%	↔	61.09%
	Eye Exam (Retinal) Performed	56.69%	53.38%	↔	54.91%
	HbA1c Testing	84.25%	84.46%	↔	84.36%
	HbA1c Control (<8.0 Percent)	44.09%	42.57%	↔	43.27%
	LDL-C Control (<100 mg/dL)	22.83%	34.46%	↑	29.09%
	LDL-C Screening	67.72%	70.27%	↔	69.09%
	Medical Attention for Nephropathy	78.74%	82.43%	↔	80.73%
	HbA1c Poor Control (>9.0 Percent)	44.88%	50.00%	↔	47.64%
Anthem Blue Cross Partnership Plan—Sacramento	Blood Pressure Control (<140/90 mm Hg)	57.74%	45.58%	↓	50.11%
	Eye Exam (Retinal) Performed	32.30%	38.94%	↑	37.75%
	HbA1c Testing	70.80%	75.66%	↔	75.28%
	HbA1c Control (<8.0 Percent)	35.84%	41.59%	↔	40.18%
	LDL-C Control (<100 mg/dL)	25.22%	30.09%	↔	29.36%
	LDL-C Screening	61.50%	67.70%	↔	64.68%
	Medical Attention for Nephropathy	67.70%	84.96%	↑	79.47%
	HbA1c Poor Control (>9.0 Percent)	52.88%	47.12%	↔	47.68%
Anthem Blue Cross Partnership Plan—San Francisco	Blood Pressure Control (<140/90 mm Hg)	66.04%	55.33%	↓	56.44%
	Eye Exam (Retinal) Performed	53.77%	48.67%	↔	49.78%
	HbA1c Testing	83.02%	82.89%	↔	82.00%
	HbA1c Control (<8.0 Percent)	40.57%	44.67%	↔	44.44%
	LDL-C Control (<100 mg/dL)	25.47%	30.89%	↔	32.00%
	LDL-C Screening	70.75%	70.44%	↔	70.44%
	Medical Attention for Nephropathy	75.47%	84.00%	↑	82.67%
	HbA1c Poor Control (>9.0 Percent)	47.17%	47.56%	↔	47.56%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Anthem Blue Cross Partnership Plan—Santa Clara	Blood Pressure Control (<140/90 mm Hg)	51.55%	40.84%	↓	44.15%
	Eye Exam (Retinal) Performed	46.90%	43.93%	↔	45.25%
	HbA1c Testing	83.19%	84.33%	↔	83.00%
	HbA1c Control (<8.0 Percent)	44.25%	44.59%	↔	45.03%
	LDL-C Control (<100 mg/dL)	39.16%	37.09%	↔	40.40%
	LDL-C Screening	78.54%	79.91%	↔	80.35%
	Medical Attention for Nephropathy	79.87%	82.78%	↔	80.13%
	HbA1c Poor Control (>9.0 Percent)	42.04%	46.58%	↔	43.27%
Anthem Blue Cross Partnership Plan—Tulare	Blood Pressure Control (<140/90 mm Hg)	59.20%	51.11%	↓	54.97%
	Eye Exam (Retinal) Performed	41.46%	42.70%	↔	47.02%
	HbA1c Testing	81.82%	83.19%	↔	83.00%
	HbA1c Control (<8.0 Percent)	39.02%	39.82%	↔	42.60%
	LDL-C Control (<100 mg/dL)	30.60%	29.42%	↔	29.36%
	LDL-C Screening	74.06%	71.46%	↔	73.07%
	Medical Attention for Nephropathy	77.61%	84.96%	↑	81.46%
	HbA1c Poor Control (>9.0 Percent)	48.12%	47.79%	↔	46.36%
CalOptima—Orange	Blood Pressure Control (<140/90 mm Hg)	74.77%	50.46%	↓	69.30%
	Eye Exam (Retinal) Performed	65.65%	63.89%	↔	67.91%
	HbA1c Testing	83.88%	86.34%	↔	85.12%
	HbA1c Control (<8.0 Percent)	48.83%	57.64%	↑	59.07%
	LDL-C Control (<100 mg/dL)	46.96%	46.53%	↔	49.77%
	LDL-C Screening	81.07%	86.81%	↑	84.88%
	Medical Attention for Nephropathy	78.97%	87.73%	↑	85.81%
	HbA1c Poor Control (>9.0 Percent)	41.36%	33.33%	▲	32.33%
CalViva Health—Fresno	Blood Pressure Control (<140/90 mm Hg)	52.07%	55.47%	↔	54.26%
	Eye Exam (Retinal) Performed	43.80%	54.01%	↑	48.42%
	HbA1c Testing	79.32%	81.75%	↔	79.81%
	HbA1c Control (<8.0 Percent)	36.50%	39.17%	↔	38.20%
	LDL-C Control (<100 mg/dL)	26.28%	34.79%	↑	32.12%
	LDL-C Screening	66.42%	74.45%	↑	72.99%
	Medical Attention for Nephropathy	69.83%	81.27%	↑	76.89%
	HbA1c Poor Control (>9.0 Percent)	57.18%	54.50%	↔	54.74%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
CalViva Health—Kings	Blood Pressure Control (<140/90 mm Hg)	39.91%	46.98%	↔	45.50%
	Eye Exam (Retinal) Performed	37.22%	52.68%	↑	48.42%
	HbA1c Testing	78.92%	80.87%	↔	78.59%
	HbA1c Control (<8.0 Percent)	37.22%	39.26%	↔	39.66%
	LDL-C Control (<100 mg/dL)	28.25%	34.56%	↔	32.12%
	LDL-C Screening	73.54%	76.51%	↔	74.21%
	Medical Attention for Nephropathy	76.68%	80.20%	↔	78.10%
	HbA1c Poor Control (>9.0 Percent)	55.61%	50.34%	↔	52.07%
CalViva Health—Madera	Blood Pressure Control (<140/90 mm Hg)	68.31%	57.53%	↓	64.96%
	Eye Exam (Retinal) Performed	59.08%	55.52%	↔	60.34%
	HbA1c Testing	88.00%	89.63%	↔	88.32%
	HbA1c Control (<8.0 Percent)	44.62%	43.81%	↔	43.07%
	LDL-C Control (<100 mg/dL)	33.23%	36.12%	↔	34.31%
	LDL-C Screening	74.46%	74.58%	↔	74.45%
	Medical Attention for Nephropathy	79.08%	87.63%	↑	82.00%
	HbA1c Poor Control (>9.0 Percent)	47.69%	49.16%	↔	49.39%
Care1st Partner Plan—San Diego	Blood Pressure Control (<140/90 mm Hg)	51.18%	41.61%	↓	46.72%
	Eye Exam (Retinal) Performed	41.34%	36.98%	↔	37.71%
	HbA1c Testing	82.28%	81.02%	↔	81.27%
	HbA1c Control (<8.0 Percent)	35.04%	44.04%	↑	42.58%
	LDL-C Control (<100 mg/dL)	26.77%	35.04%	↑	32.36%
	LDL-C Screening	70.47%	72.51%	↔	72.99%
	Medical Attention for Nephropathy	73.62%	81.27%	↑	82.24%
	HbA1c Poor Control (>9.0 Percent)	71.65%	64.72%	↔	51.82%
CenCal Health—San Luis Obispo	Blood Pressure Control (<140/90 mm Hg)	67.71%	68.56%	↔	65.94%
	Eye Exam (Retinal) Performed	57.81%	61.47%	↔	59.12%
	HbA1c Testing	83.85%	83.85%	↔	84.18%
	HbA1c Control (<8.0 Percent)	50.00%	61.76%	↑	58.15%
	LDL-C Control (<100 mg/dL)	33.85%	45.04%	↑	40.15%
	LDL-C Screening	77.60%	80.74%	↔	79.08%
	Medical Attention for Nephropathy	80.73%	88.39%	↑	85.40%
	HbA1c Poor Control (>9.0 Percent)	35.94%	27.76%	▲	30.90%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
CenCal Health—Santa Barbara	Blood Pressure Control (<140/90 mm Hg)	71.53%	67.64%	↔	72.02%
	Eye Exam (Retinal) Performed	66.18%	66.18%	↔	68.61%
	HbA1c Testing	84.18%	87.10%	↔	86.37%
	HbA1c Control (<8.0 Percent)	56.20%	63.50%	↑	59.37%
	LDL-C Control (<100 mg/dL)	36.98%	45.01%	↑	40.39%
	LDL-C Screening	79.56%	79.32%	↔	80.05%
	Medical Attention for Nephropathy	81.02%	86.13%	↑	84.91%
	HbA1c Poor Control (>9.0 Percent)	33.33%	26.76%	▲	31.87%
Central California Alliance for Health—Merced	Blood Pressure Control (<140/90 mm Hg)	50.85%	43.31%	↓	62.53%
	Eye Exam (Retinal) Performed	49.64%	51.82%	↔	53.53%
	HbA1c Testing	85.16%	88.32%	↔	83.94%
	HbA1c Control (<8.0 Percent)	36.01%	39.42%	↔	44.28%
	LDL-C Control (<100 mg/dL)	25.06%	28.47%	↔	32.85%
	LDL-C Screening	78.35%	81.02%	↔	78.59%
	Medical Attention for Nephropathy	78.83%	86.86%	↑	81.27%
	HbA1c Poor Control (>9.0 Percent)	57.18%	52.07%	↔	45.74%
Central California Alliance for Health—Monterey/Santa Cruz	Blood Pressure Control (<140/90 mm Hg)	62.29%	59.85%	↔	75.18%
	Eye Exam (Retinal) Performed	51.09%	62.04%	↑	56.45%
	HbA1c Testing	81.27%	88.08%	↑	86.86%
	HbA1c Control (<8.0 Percent)	40.15%	51.82%	↑	51.82%
	LDL-C Control (<100 mg/dL)	31.39%	37.96%	↑	35.77%
	LDL-C Screening	73.97%	81.75%	↑	79.81%
	Medical Attention for Nephropathy	75.67%	82.97%	↑	79.32%
	HbA1c Poor Control (>9.0 Percent)	50.36%	40.88%	▲	38.20%
Community Health Group Partnership Plan—San Diego	Blood Pressure Control (<140/90 mm Hg)	47.93%	44.04%	↔	45.99%
	Eye Exam (Retinal) Performed	51.34%	57.18%	↔	55.47%
	HbA1c Testing	82.73%	86.86%	↔	86.13%
	HbA1c Control (<8.0 Percent)	43.31%	46.47%	↔	45.01%
	LDL-C Control (<100 mg/dL)	32.85%	42.58%	↑	39.66%
	LDL-C Screening	77.86%	82.97%	↔	81.75%
	Medical Attention for Nephropathy	73.72%	84.91%	↑	81.27%
	HbA1c Poor Control (>9.0 Percent)	42.82%	39.66%	↔	40.88%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Contra Costa Health Plan—Contra Costa	Blood Pressure Control (<140/90 mm Hg)	59.37%	62.77%	↔	61.31%
	Eye Exam (Retinal) Performed	45.74%	52.55%	↔	51.34%
	HbA1c Testing	79.32%	84.43%	↔	84.43%
	HbA1c Control (<8.0 Percent)	35.28%	54.01%	↑	48.18%
	LDL-C Control (<100 mg/dL)	32.12%	42.58%	↑	42.34%
	LDL-C Screening	69.83%	75.91%	↑	75.67%
	Medical Attention for Nephropathy	74.94%	83.21%	↑	83.94%
	HbA1c Poor Control (>9.0 Percent)	54.01%	36.98%	▲	41.61%
Gold Coast Health Plan—Ventura	Blood Pressure Control (<140/90 mm Hg)	60.83%	59.85%	↔	61.31%
	Eye Exam (Retinal) Performed	42.34%	44.04%	↔	45.74%
	HbA1c Testing	84.43%	85.16%	↔	85.16%
	HbA1c Control (<8.0 Percent)	45.01%	49.88%	↔	45.50%
	LDL-C Control (<100 mg/dL)	25.30%	34.79%	↑	28.47%
	LDL-C Screening	77.37%	80.05%	↔	79.56%
	Medical Attention for Nephropathy	75.67%	81.51%	↑	78.10%
	HbA1c Poor Control (>9.0 Percent)	46.47%	42.34%	↔	45.50%
Health Net Community Solutions, Inc.—Kern	Blood Pressure Control (<140/90 mm Hg)	52.31%	48.66%	↔	50.36%
	Eye Exam (Retinal) Performed	44.53%	46.72%	↔	42.34%
	HbA1c Testing	78.10%	79.32%	↔	76.89%
	HbA1c Control (<8.0 Percent)	27.25%	39.17%	↑	33.33%
	LDL-C Control (<100 mg/dL)	25.06%	40.63%	↑	35.52%
	LDL-C Screening	70.56%	77.62%	↑	74.45%
	Medical Attention for Nephropathy	76.16%	82.48%	↑	79.32%
	HbA1c Poor Control (>9.0 Percent)	64.48%	54.50%	▲	60.10%
Health Net Community Solutions, Inc.—Los Angeles	Blood Pressure Control (<140/90 mm Hg)	64.72%	53.04%	↓	59.61%
	Eye Exam (Retinal) Performed	51.34%	48.42%	↔	50.36%
	HbA1c Testing	81.75%	79.56%	↔	79.81%
	HbA1c Control (<8.0 Percent)	39.66%	45.01%	↔	45.26%
	LDL-C Control (<100 mg/dL)	30.90%	39.17%	↑	37.23%
	LDL-C Screening	74.94%	78.83%	↔	77.62%
	Medical Attention for Nephropathy	80.29%	83.45%	↔	81.27%
	HbA1c Poor Control (>9.0 Percent)	50.85%	45.50%	↔	48.66%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Health Net Community Solutions, Inc.— Sacramento	Blood Pressure Control (<140/90 mm Hg)	49.39%	47.20%	↔	45.99%
	Eye Exam (Retinal) Performed	35.77%	41.12%	↔	37.96%
	HbA1c Testing	71.29%	78.10%	↑	77.62%
	HbA1c Control (<8.0 Percent)	38.44%	48.91%	↑	48.18%
	LDL-C Control (<100 mg/dL)	26.28%	35.28%	↑	33.33%
	LDL-C Screening	63.75%	71.29%	↑	67.64%
	Medical Attention for Nephropathy	71.53%	82.00%	↑	80.29%
	HbA1c Poor Control (>9.0 Percent)	54.99%	43.80%	▲	46.23%
Health Net Community Solutions, Inc.— San Diego	Blood Pressure Control (<140/90 mm Hg)	46.58%	46.47%	↔	46.23%
	Eye Exam (Retinal) Performed	47.26%	38.93%	↔	44.77%
	HbA1c Testing	68.49%	76.16%	↔	77.13%
	HbA1c Control (<8.0 Percent)	34.93%	40.15%	↔	38.69%
	LDL-C Control (<100 mg/dL)	25.34%	33.09%	↔	30.90%
	LDL-C Screening	63.01%	70.07%	↔	70.32%
	Medical Attention for Nephropathy	69.86%	80.29%	↑	78.10%
	HbA1c Poor Control (>9.0 Percent)	56.16%	53.28%	↔	54.01%
Health Net Community Solutions, Inc.— San Joaquin	Blood Pressure Control (<140/90 mm Hg)	36.51%	33.33%	↔	34.96%
	Eye Exam (Retinal) Performed	34.92%	43.33%	↔	39.02%
	HbA1c Testing	60.32%	86.67%	↑	73.17%
	HbA1c Control (<8.0 Percent)	20.63%	38.33%	↑	29.27%
	LDL-C Control (<100 mg/dL)	17.46%	40.00%	↑	28.46%
	LDL-C Screening	60.32%	60.00%	↔	60.16%
	Medical Attention for Nephropathy	76.19%	86.67%	↔	81.30%
	HbA1c Poor Control (>9.0 Percent)	74.60%	55.00%	▲	65.04%
Health Net Community Solutions— Stanislaus	Blood Pressure Control (<140/90 mm Hg)	63.99%	55.72%	↓	58.64%
	Eye Exam (Retinal) Performed	41.61%	40.39%	↔	41.36%
	HbA1c Testing	82.97%	87.10%	↔	87.10%
	HbA1c Control (<8.0 Percent)	46.23%	54.01%	↑	51.82%
	LDL-C Control (<100 mg/dL)	34.06%	42.34%	↑	41.36%
	LDL-C Screening	73.48%	77.86%	↔	77.62%
	Medical Attention for Nephropathy	71.05%	81.75%	↑	78.35%
	HbA1c Poor Control (>9.0 Percent)	42.09%	36.50%	↔	37.23%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Health Net Community Solutions, Inc.—Tulare	Blood Pressure Control (<140/90 mm Hg)	60.34%	55.96%	↔	55.96%
	Eye Exam (Retinal) Performed	40.88%	50.85%	↑	50.12%
	HbA1c Testing	79.08%	80.29%	↔	79.56%
	HbA1c Control (<8.0 Percent)	41.61%	48.42%	↑	45.26%
	LDL-C Control (<100 mg/dL)	28.47%	33.82%	↔	30.66%
	LDL-C Screening	71.78%	70.80%	↔	69.34%
	Medical Attention for Nephropathy	71.53%	84.18%	↑	79.56%
	HbA1c Poor Control (>9.0 Percent)	51.09%	44.77%	↔	47.45%
Health Plan of San Joaquin—San Joaquin	Blood Pressure Control (<140/90 mm Hg)	59.61%	69.10%	↑	65.69%
	Eye Exam (Retinal) Performed	41.85%	42.34%	↔	44.77%
	HbA1c Testing	72.02%	81.75%	↑	79.08%
	HbA1c Control (<8.0 Percent)	43.80%	56.45%	↑	51.82%
	LDL-C Control (<100 mg/dL)	32.12%	46.72%	↑	41.12%
	LDL-C Screening	68.86%	78.10%	↑	75.18%
	Medical Attention for Nephropathy	68.37%	84.18%	↑	79.08%
	HbA1c Poor Control (>9.0 Percent)	47.69%	36.25%	▲	40.15%
Health Plan of San Joaquin—Stanislaus	Blood Pressure Control (<140/90 mm Hg)	66.58%	66.42%	↔	67.88%
	Eye Exam (Retinal) Performed	31.78%	39.17%	↑	37.23%
	HbA1c Testing	83.01%	88.56%	↑	85.40%
	HbA1c Control (<8.0 Percent)	48.22%	59.37%	↑	52.31%
	LDL-C Control (<100 mg/dL)	39.73%	43.55%	↔	40.63%
	LDL-C Screening	72.33%	81.75%	↑	74.94%
	Medical Attention for Nephropathy	76.16%	83.70%	↑	80.29%
	HbA1c Poor Control (>9.0 Percent)	41.37%	31.14%	▲	36.98%
Health Plan of San Mateo—San Mateo	Blood Pressure Control (<140/90 mm Hg)	52.31%	46.72%	↔	46.72%
	Eye Exam (Retinal) Performed	50.36%	63.99%	↑	60.83%
	HbA1c Testing	81.75%	88.81%	↑	87.10%
	HbA1c Control (<8.0 Percent)	47.93%	56.93%	↑	54.01%
	LDL-C Control (<100 mg/dL)	36.50%	47.20%	↑	42.82%
	LDL-C Screening	75.43%	84.91%	↑	80.78%
	Medical Attention for Nephropathy	82.00%	90.75%	↑	90.02%
	HbA1c Poor Control (>9.0 Percent)	43.07%	36.01%	▲	38.69%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Inland Empire Health Plan—Riverside/San Bernardino	Blood Pressure Control (<140/90 mm Hg)	67.26%	60.18%	↓	62.88%
	Eye Exam (Retinal) Performed	46.46%	56.11%	↑	51.74%
	HbA1c Testing	78.98%	87.33%	↑	84.69%
	HbA1c Control (<8.0 Percent)	42.48%	50.68%	↑	46.87%
	LDL-C Control (<100 mg/dL)	34.29%	43.21%	↑	40.60%
	LDL-C Screening	76.33%	85.29%	↑	81.67%
	Medical Attention for Nephropathy	75.44%	89.37%	↑	82.13%
	HbA1c Poor Control (>9.0 Percent)	49.56%	33.71%	▲	39.44%
Kaiser North—Sacramento	Blood Pressure Control (<140/90 mm Hg)	79.51%	80.20%	↔	80.00%
	Eye Exam (Retinal) Performed	58.49%	66.44%	↑	64.11%
	HbA1c Testing	91.64%	95.64%	↑	94.47%
	HbA1c Control (<8.0 Percent)	46.09%	65.66%	↑	59.92%
	LDL-C Control (<100 mg/dL)	54.99%	74.50%	↑	68.77%
	LDL-C Screening	90.30%	94.41%	↑	93.20%
	Medical Attention for Nephropathy	89.49%	95.08%	↑	93.44%
	HbA1c Poor Control (>9.0 Percent)	38.01%	23.15%	▲	27.51%
Kaiser South—San Diego	Blood Pressure Control (<140/90 mm Hg)	88.89%	88.84%	↔	88.86%
	Eye Exam (Retinal) Performed	79.06%	82.96%	↔	81.71%
	HbA1c Testing	96.15%	96.75%	↔	96.56%
	HbA1c Control (<8.0 Percent)	61.97%	72.62%	↑	69.19%
	LDL-C Control (<100 mg/dL)	58.12%	74.44%	↑	69.19%
	LDL-C Screening	92.74%	95.74%	↔	94.77%
	Medical Attention for Nephropathy	92.74%	95.94%	↔	94.91%
	HbA1c Poor Control (>9.0 Percent)	21.37%	16.23%	↔	17.88%
Kern Family Health Care—Kern	Blood Pressure Control (<140/90 mm Hg)	76.89%	72.75%	↔	75.67%
	Eye Exam (Retinal) Performed	47.20%	44.77%	↔	45.01%
	HbA1c Testing	80.29%	80.78%	↔	80.05%
	HbA1c Control (<8.0 Percent)	46.72%	49.39%	↔	44.53%
	LDL-C Control (<100 mg/dL)	34.79%	40.15%	↔	37.71%
	LDL-C Screening	77.37%	80.78%	↔	77.86%
	Medical Attention for Nephropathy	79.81%	83.21%	↔	82.48%
	HbA1c Poor Control (>9.0 Percent)	47.69%	38.20%	▲	46.96%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
L.A. Care Health Plan—Los Angeles	Blood Pressure Control (<140/90 mm Hg)	48.66%	45.50%	↔	60.05%
	Eye Exam (Retinal) Performed	43.31%	45.50%	↔	46.25%
	HbA1c Testing	80.78%	84.67%	↔	83.54%
	HbA1c Control (<8.0 Percent)	38.20%	50.12%	↑	41.65%
	LDL-C Control (<100 mg/dL)	36.25%	39.42%	↔	36.08%
	LDL-C Screening	79.32%	82.97%	↔	80.15%
	Medical Attention for Nephropathy	80.05%	88.56%	↑	84.99%
	HbA1c Poor Control (>9.0 Percent)	51.82%	42.34%	▲	47.46%
Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino	Blood Pressure Control (<140/90 mm Hg)	54.97%	49.34%	↔	59.60%
	Eye Exam (Retinal) Performed	42.16%	45.13%	↔	50.99%
	HbA1c Testing	79.69%	78.76%	↔	82.56%
	HbA1c Control (<8.0 Percent)	34.88%	40.71%	↔	38.19%
	LDL-C Control (<100 mg/dL)	30.91%	35.62%	↔	34.00%
	LDL-C Screening	76.82%	78.32%	↔	79.69%
	Medical Attention for Nephropathy	76.38%	82.96%	↑	81.90%
	HbA1c Poor Control (>9.0 Percent)	54.53%	48.23%	↔	48.79%
Molina Healthcare of California Partner Plan, Inc.—Sacramento	Blood Pressure Control (<140/90 mm Hg)	42.49%	51.66%	↑	52.76%
	Eye Exam (Retinal) Performed	44.02%	50.33%	↔	48.79%
	HbA1c Testing	74.81%	76.82%	↔	79.25%
	HbA1c Control (<8.0 Percent)	39.44%	45.92%	↔	45.25%
	LDL-C Control (<100 mg/dL)	28.75%	33.11%	↔	34.44%
	LDL-C Screening	68.70%	73.73%	↔	75.28%
	Medical Attention for Nephropathy	72.77%	81.90%	↑	79.47%
	HbA1c Poor Control (>9.0 Percent)	50.89%	44.59%	↔	46.36%
Molina Healthcare of California Partner Plan, Inc.—San Diego	Blood Pressure Control (<140/90 mm Hg)	55.85%	53.86%	↔	60.71%
	Eye Exam (Retinal) Performed	43.27%	56.73%	↑	55.63%
	HbA1c Testing	82.78%	88.08%	↑	87.64%
	HbA1c Control (<8.0 Percent)	45.03%	52.54%	↑	49.45%
	LDL-C Control (<100 mg/dL)	34.22%	43.05%	↑	40.18%
	LDL-C Screening	76.38%	83.00%	↑	82.12%
	Medical Attention for Nephropathy	76.38%	88.30%	↑	84.99%
	HbA1c Poor Control (>9.0 Percent)	47.02%	39.51%	▲	41.50%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
Partnership HealthPlan of California—Marin	Blood Pressure Control (<140/90 mm Hg)	74.70%	68.39%	↔	70.29%
	Eye Exam (Retinal) Performed	49.40%	49.74%	↔	49.64%
	HbA1c Testing	84.34%	90.67%	↔	88.77%
	HbA1c Control (<8.0 Percent)	44.58%	50.78%	↔	48.91%
	LDL-C Control (<100 mg/dL)	30.12%	44.56%	↑	40.22%
	LDL-C Screening	73.49%	77.72%	↔	76.45%
	Medical Attention for Nephropathy	77.11%	86.53%	↔	83.70%
	HbA1c Poor Control (>9.0 Percent)	45.78%	43.01%	↔	43.84%
Partnership HealthPlan of California—Mendocino	Blood Pressure Control (<140/90 mm Hg)	62.44%	64.73%	↔	63.74%
	Eye Exam (Retinal) Performed	31.47%	45.35%	↑	39.34%
	HbA1c Testing	81.73%	83.33%	↔	82.64%
	HbA1c Control (<8.0 Percent)	35.53%	45.74%	↑	41.32%
	LDL-C Control (<100 mg/dL)	23.86%	33.33%	↑	29.23%
	LDL-C Screening	62.44%	68.22%	↔	65.71%
	Medical Attention for Nephropathy	67.51%	81.01%	↑	75.16%
	HbA1c Poor Control (>9.0 Percent)	54.82%	45.74%	↔	49.67%
Partnership HealthPlan of California—Napa/Solano/Yolo	Blood Pressure Control (<140/90 mm Hg)	69.83%	61.07%	↓	65.21%
	Eye Exam (Retinal) Performed	50.85%	62.04%	↑	60.34%
	HbA1c Testing	82.24%	83.45%	↔	82.48%
	HbA1c Control (<8.0 Percent)	47.93%	54.50%	↔	52.31%
	LDL-C Control (<100 mg/dL)	36.98%	48.91%	↑	46.96%
	LDL-C Screening	75.43%	78.10%	↔	77.86%
	Medical Attention for Nephropathy	81.27%	89.54%	↑	86.86%
	HbA1c Poor Control (>9.0 Percent)	41.61%	35.28%	↔	37.47%
Partnership HealthPlan of California—Sonoma	Blood Pressure Control (<140/90 mm Hg)	78.80%	66.42%	↓	70.56%
	Eye Exam (Retinal) Performed	57.61%	59.37%	↔	60.10%
	HbA1c Testing	91.58%	87.59%	↔	89.05%
	HbA1c Control (<8.0 Percent)	50.82%	54.01%	↔	52.55%
	LDL-C Control (<100 mg/dL)	40.49%	41.61%	↔	41.12%
	LDL-C Screening	80.16%	78.10%	↔	79.81%
	Medical Attention for Nephropathy	78.80%	83.45%	↔	82.24%
	HbA1c Poor Control (>9.0 Percent)	36.14%	36.25%	↔	34.55%

SENIORS AND PERSONS WITH DISABILITIES POPULATION

MCP Name/County	Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD	Total Rate (Non-SPD and SPD)
San Francisco Health Plan—San Francisco	Blood Pressure Control (<140/90 mm Hg)	76.80%	69.91%	↓	76.57%
	Eye Exam (Retinal) Performed	69.14%	62.27%	↓	62.41%
	HbA1c Testing	88.63%	88.43%	↔	89.33%
	HbA1c Control (<8.0 Percent)	66.13%	65.05%	↔	63.57%
	LDL-C Control (<100 mg/dL)	51.04%	47.92%	↔	47.80%
	LDL-C Screening	80.51%	78.24%	↔	79.35%
	Medical Attention for Nephropathy	85.38%	85.42%	↔	86.77%
	HbA1c Poor Control (>9.0 Percent)	22.27%	23.84%	↔	24.36%
Santa Clara Family Health—Santa Clara	Blood Pressure Control (<140/90 mm Hg)	58.64%	51.09%	↓	56.69%
	Eye Exam (Retinal) Performed	47.45%	44.53%	↔	46.72%
	HbA1c Testing	80.29%	86.86%	↑	86.86%
	HbA1c Control (<8.0 Percent)	48.42%	56.45%	↑	54.01%
	LDL-C Control (<100 mg/dL)	36.74%	49.15%	↑	41.36%
	LDL-C Screening	72.75%	80.29%	↑	81.02%
	Medical Attention for Nephropathy	77.86%	87.35%	↑	83.45%
	HbA1c Poor Control (>9.0 Percent)	40.63%	34.06%	↔	33.82%

Ambulatory Care

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

**Table 8.5—HEDIS 2014 Medi-Cal Managed Care Ambulatory Care Measure
SPD versus Non-SPD**

MCP Name	County	Non-SPD Visits/1,000 Member Months		SPD Visits/1,000 Member Months	
		Outpatient Visits	ED Visits	Outpatient Visits	ED Visits
Alameda Alliance for Health	Alameda	212.26	24.72	387.05	53.35
Anthem Blue Cross Partnership Plan	Alameda	187.84	53.18	294.17	115.98
Anthem Blue Cross Partnership Plan	Contra Costa	225.26	56.15	284.86	97.01
Anthem Blue Cross Partnership Plan	Fresno	219.48	45.59	367.46	74.31
Anthem Blue Cross Partnership Plan	Kings	291.39	61.93	563.40	119.47
Anthem Blue Cross Partnership Plan	Madera	272.13	54.40	509.81	98.73
Anthem Blue Cross Partnership Plan	Sacramento	191.26	48.19	356.44	82.77
Anthem Blue Cross Partnership Plan	San Francisco	245.67	35.87	373.20	95.72
Anthem Blue Cross Partnership Plan	Santa Clara	232.83	41.56	374.95	74.19
Anthem Blue Cross Partnership Plan	Tulare	305.19	39.20	561.54	83.89
CalOptima	Orange	226.81	32.50	573.24	51.03
CalViva Health	Fresno	458.67	47.62	555.25	70.05
CalViva Health	Kings	403.24	55.66	651.69	113.80
CalViva Health	Madera	464.83	49.54	665.45	78.44
Care1st Partner Plan	San Diego	237.00	44.72	399.63	68.85
CenCal Health	San Luis Obispo	296.02	53.41	598.85	95.46
CenCal Health	Santa Barbara	272.79	46.42	596.56	102.10
Central California Alliance for Health	Merced	297.38	50.05	539.90	76.83
Central California Alliance for Health	Monterey/Santa Cruz	282.10	44.17	549.69	74.76
Community Health Group Partnership Plan	San Diego	280.48	35.06	384.72	46.05
Contra Costa Health Plan	Contra Costa	223.77	48.06	342.49	74.83
Gold Coast Health Plan	Ventura	189.20	35.36	361.16	64.02
Health Net Community Solutions, Inc.	Kern	359.51	48.90	302.99	83.64
Health Net Community Solutions, Inc.	Los Angeles	277.13	32.38	262.13	52.60
Health Net Community Solutions, Inc.	Sacramento	293.32	39.23	358.78	64.11
Health Net Community Solutions, Inc.	San Diego	362.03	41.81	319.25	69.30

SENIORS AND PERSONS WITH DISABILITIES POPULATION

		Non-SPD Visits/1,000 Member Months		SPD Visits/1,000 Member Months	
MCP Name	County	Outpatient Visits	ED Visits	Outpatient Visits	ED Visits
Health Net Community Solutions, Inc.	San Joaquin	256.64	46.94	344.91	104.16
Health Net Community Solutions, Inc.	Stanislaus	378.60	56.78	470.09	93.41
Health Net Community Solutions, Inc.	Tulare	486.43	38.64	651.79	70.74
Health Plan of San Joaquin	San Joaquin	223.43	42.34	438.00	71.99
Health Plan of San Joaquin	Stanislaus	244.19	51.51	585.69	105.58
Health Plan of San Mateo	San Mateo	326.37	44.87	797.31	60.39
Inland Empire Health Plan	Riverside/San Bernardino	247.47	44.44	632.06	82.89
Kaiser North	Sacramento	313.74	41.86	699.94	84.30
Kaiser South	San Diego	343.04	26.61	890.21	59.41
Kern Family Health Care	Kern	248.15	46.93	492.89	99.42
L.A. Care Health Plan	Los Angeles	294.71	32.50	421.46	57.87
Molina Healthcare of California Partner Plan, Inc.	Riverside/San Bernardino	192.15	35.41	312.01	72.83
Molina Healthcare of California Partner Plan, Inc.	Sacramento	204.58	44.36	423.73	68.46
Molina Healthcare of California Partner Plan, Inc.	San Diego	197.22	35.84	434.68	71.93
Partnership HealthPlan of California	Marin	308.78	40.32	538.03	61.72
Partnership HealthPlan of California	Mendocino	267.41	50.11	586.07	95.80
Partnership HealthPlan of California	Napa/Solano/Yolo	240.94	45.79	565.93	81.68
Partnership HealthPlan of California	Sonoma	319.83	34.76	597.96	72.33
San Francisco Health Plan	San Francisco	330.07	23.26	615.01	75.73
Santa Clara Family Health Plan	Santa Clara	240.37	30.95	411.17	45.66

This section provides a summary of the findings and conclusions for full-scope MCPs and recommendations for DHCS related to full-scope and specialty MCPs.

Performance Measure HEDIS Compliance Audit—Key Findings

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

Minimum and High Performance Levels

Consistent with 2013, MPLs and HPLs were not established for the following measures:

- ◆ *All-Cause Readmissions*—developed for the statewide collaborative QIP
- ◆ *Ambulatory Care*—utilization measures
 - *Outpatient Visits*
 - *Emergency Department Visits*

Additionally, although MPLs and HPLs were established for the following measures, DHCS did not hold the MCPs to the MPLs for these measures for 2014:

- ◆ All four *Children and Adolescents' Access to Primary Care Practitioners* measures—to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact.
- ◆ *Cervical Cancer Screening*—because NCQA made changes to the specifications for HEDIS 2014 to reflect the new screening guidelines.
- ◆ *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* and *LDL-C Screening* measures—because NCQA removed these measures from the HEDIS measure set beginning with HEDIS 2015.

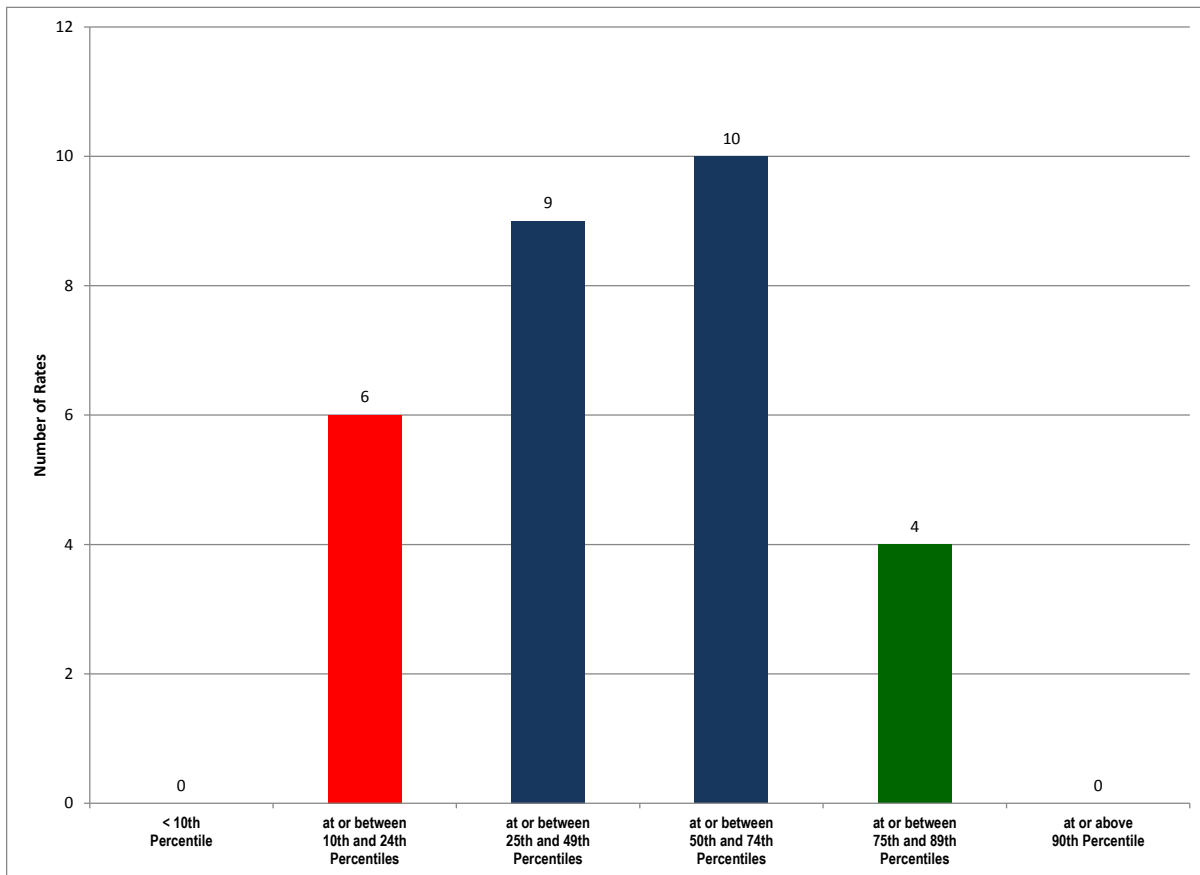
For the following measures, 2014 was the first year DHCS held the MCPs accountable to meet the MPL:

- ◆ *Controlling High Blood Pressure*
- ◆ *Medication Management for People with Asthma—Medication Compliance 50%*
- ◆ *Medication Management for People with Asthma—Medication Compliance 75%*

Comparisons to National Benchmarks

Figure 9.1 shows the 2014 MCMC weighted averages compared to the 2013 national Medicaid benchmarks.^{126,127} Consistent with 2013, most of the weighted averages were at or between the 25th and 74th percentiles; however, there was a greater percentage of weighted averages in this range in 2014—66 percent compared to 46 percent in 2013. In 2014, 21 percent of the weighted averages were at or between the 10th and 24th national Medicaid percentiles compared to 31 percent in 2013. In 2014, 14 percent of the weighted averages were at or between the 75th and 89th percentiles compared to 23 percent in 2013. Consistent with 2013, no weighted averages were less than the 10th or greater than the 90th percentiles. (Note: In 2014, 29 measures were compared to the national percentiles, and 26 measures were compared to the benchmarks in 2013).

Figure 9.1—2014 Medi-Cal Managed Care Weighted Average Performance Compared to 2013 National Medicaid Benchmarks¹²⁸



¹²⁶ The 2014 MCMC weighted averages are compared to national HEDIS 2013 benchmarks, representing calendar year 2012 data.

¹²⁷ The weighted averages for the *All-Cause Readmissions* and *Ambulatory Care* measures are not compared to the national Medicaid benchmarks and are not included in the chart.

¹²⁸ The 2014 MCMC weighted averages are compared to national HEDIS 2013 benchmarks, representing calendar year 2012 data.

Following is a summary of the 2014 MCMC weighted averages compared to the MPLs, national Medicaid average, national commercial averages, and Healthy People 2020 goals (as applicable) for each measure:

- ◆ The weighted averages for 23 measures were above the MPLs. (Note: For all measures except *Comprehensive Diabetes Care HbA1c Poor Control [>9.0 Percent]*, the MPLs are based on the 25th national Medicaid percentile. For the *Comprehensive Diabetes Care HbA1c Poor Control [>9.0 Percent]* measure, the MPL is based on the national Medicaid 75th percentile because for this measure, a lower rate means better performance).
 - The weighted average for the *Annual Monitoring for Patients on Persistent Medications—Digoxin* measure improved from below the MPL in 2013 to above the MPL in 2014.
 - The weighted average for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure improved from below the MPL in 2013 to above the MPL in 2014.
- ◆ The weighted averages for the following measures were below DHCS’s established MPLs:
 - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*—for the third consecutive year.
 - All four *Children and Adolescents’ Access to Primary Care Practitioners* measures.
 - *12–24 Months* and *25 Months to 6 Years*—for the second consecutive year.
 - *7 to 11 Years* and *12 to 19 Years*—for the third consecutive year.
 - *Prenatal and Postpartum Care—Postpartum Care*—for the second consecutive year.
- ◆ The weighted averages for 17 measures were above the national Medicaid averages for the measures, and 13 of these rates were above the national Medicaid averages for the fourth consecutive year.
- ◆ The weighted averages for 12 measures were below the national Medicaid averages for the measures.
 - The weighted averages for the *Comprehensive Diabetes Care—HbA1c Testing* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure moved from above the national Medicaid averages in 2013 to below the national Medicaid averages in 2014.
- ◆ The weighted averages for 10 measures were above the national commercial averages for the measures in 2014:
 - The rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Annual Monitoring for Patients on Persistent Medications—Diuretics* measures moved from below the national commercial averages in 2013 to above the national commercial average in 2014.
- ◆ The weighted averages for 19 measures were below the national commercial averages for the measures in 2014.

- ◆ For the fourth consecutive year, the weighted averages for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures were higher than the Healthy People 2020 goals for the measures.
- ◆ The weighted averages for the following measures fell short of the Healthy People 2020 goals for the measures:
 - *Cervical Cancer Screening*
 - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
 - *Comprehensive Diabetes Care—LDL-C Control*
 - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
 - *Controlling High Blood Pressure*

High and Low Managed Care Health Plan County Performance

Three MCPs demonstrated high performance across the EAS, exceeding 14 or more of DHCS’s established HPLs, and only one of these MCPs had measures with rates below the MPLs. These MCPs were also among the top-performing MCPs in 2013:

- ◆ Kaiser North—Sacramento County: 22 measures with rates above the HPLs, and two measures with rates below the MPLs.
- ◆ Kaiser South—San Diego County: 20 measures with rates above the HPLs, and no measures with rates below the MPLs.
- ◆ San Francisco Health Plan—San Francisco County: 14 measures with rates above the HPLs, and no measures with rates below the MPLs.

Thirteen MCP counties showed the greatest opportunity for improvement by having 10 or more measures below the DHCS-established MPLs:

- ◆ Alameda Alliance for Health—Alameda County (10 measures)
- ◆ Anthem Blue Cross Partnership Plan—Alameda County (22 measures), Contra Costa County (16 measures), Fresno County (13 measures), Kings County (19 measures), and Sacramento County (15 measures)
- ◆ Cal Viva Health—Kings County (14 measures)
- ◆ Care1st Partner Plan—San Diego County (11 measures)
- ◆ Health Net Community Solutions, Inc.—Kern County (16 measures), Sacramento County (16 measures), and San Diego County (12 measures). (Note: The rates for 15 measures were below the MPLs in San Joaquin County; however, 2014 was the first year Health Net Community

Solutions, Inc., reported rates for San Joaquin County and DHCS therefore did not hold the MCP accountable to meet the MPLs for this county.)

- ◆ Molina Healthcare of California Partner Plan, Inc.—Sacramento County (13 measures)

Notable Performance Measures

The performance measure results were mixed in that some rates improved from 2013 to 2014, some declined, and some remained relatively stable. The MCPs performed the best on the following measures:

- ◆ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
 - For the fourth consecutive year, the MCMC weighted average for this measure was above the national Medicaid 25th percentile and national Medicaid and commercial averages for the measure.
 - Twelve MCP county rates were above the HPL for this measure, and four rates improved significantly from 2013 to 2014.
 - Four MCP county rates were below the MPL for this measure, and seven rates declined significantly from 2013 to 2014.
- ◆ *Use of Imaging Studies for Low Back Pain*
 - For the fourth consecutive year, the MCMC weighted average for this measure was above the national Medicaid 25th percentile and national Medicaid and commercial averages for the measure.
 - Twenty-three MCP county rates were above the HPL for this measure, and three rates improved significantly from 2013 to 2014.
 - Three MCP county rates were below the MPL for this measure, and four rates declined significantly from 2013 to 2014.
- ◆ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity: Total*
 - For the fourth consecutive year, the MCMC weighted average for this measure was above the national Medicaid 25th percentile, national Medicaid and commercial averages, and Healthy People 2020 goal for the measure.
 - Eleven MCP county rates were above the HPL for this measure, and 12 rates improved significantly from 2013 to 2014.
 - Two MCP county rates were below the MPL, and three rates declined significantly from 2013 to 2014.

Although there are many opportunities for improvement, the following measures, which had weighted averages below the DHCS-established MPLs for at least two consecutive years, show the greatest opportunities for improvement:

- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
 - The rates for 19 MCP counties improved significantly from 2013 to 2014; however, 21 MCP county rates remained below the MPL.
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
 - The rates for nine MCP counties improved significantly from 2013 to 2014; however, three MCP county rates declined significantly, and 18 MCP county rates were below the MPL.
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
 - The rates for 22 MCP counties improved significantly from 2013 to 2014; however, five MCP county rates declined significantly, and 18 rates were below the MPL.
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
 - The rates for 18 MCP counties improved significantly from 2013 to 2014; however, four MCP county rates declined significantly, and 24 rates were below the MPL.
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
 - The rates for four MCP counties improved significantly from 2013 to 2014; however, 23 MCP county rates declined significantly, and 27 rates were below the MPL.
- ◆ *Prenatal and Postpartum Care—Postpartum Care*
 - The rates for four MCP counties improved significantly from 2013 to 2014; however, six MCP county rates declined significantly, and 19 rates were below the MPL.

Seniors and Persons with Disabilities

Consistent with 2013, the SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* measures were significantly higher than the non-SPD rates. Also consistent with 2013, the SPD rates for all *Comprehensive Diabetes Care* measures, except *Blood Pressure Control (<140/90 mm Hg)*, were better than the non-SPD rates. The better rates for these measures may be attributed to SPD members having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

For the second consecutive year, the SPD population had a significantly higher rate of readmissions than the non-SPD population, which is also expected based on the greater and often more complicated health needs of these members. Additionally, the rates for several MCP counties for the *Children and Adolescents' Access to Primary Care Practitioners* measures were significantly lower for the SPD population when compared to the non-SPD population. The lower

rates for this measure may be attributed to children and adolescents in the SPD population relying on a specialist provider as their care source, based on complicated health care needs, rather than accessing care from a PCP.

Model Type Performance

As in 2013, the County-Organized Health System (COHS) model outperformed the Geographic Managed Care (GMC) model and Two-Plan Model (TPM) types on 24 of the 30 performance measures. (Note: HSAG does not make comparisons for the two *Ambulatory Care* measures because they are utilization measures. The GMC model outperformed the other models on five measures, and the TPM outperformed the other model types on the remaining one measure).

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

Conclusions and Recommendations

DHCS demonstrates continued commitment to monitor and improve the quality of care delivered to MCMC beneficiaries through development of its External Accountability Set (EAS) that supports MCMC's overall quality strategy. DHCS uses a collaborative approach with MCPs to identify if changes need to be made to the EAS, meeting with them to discuss potential changes and obtaining input on proposed new measures. This collaborative approach ensures that DHCS and MCP priorities are considered and that the measures chosen for the EAS are reflective of areas in need of improvement to ensure quality, timely, and accessible health care for Medi-Cal beneficiaries.

DHCS continued a variety of actions to support the improvement efforts of MCPs. DHCS worked with MCPs on implementing rapid cycle improvement strategies as part of their improvement plans for measures with rates below the DHCS-established minimum performance levels (MPLs). Additionally, DHCS continued to support MCPs in selecting performance measures for formal QIPs to help structure improvement efforts to increase the likelihood of achieving statistically significant and sustained improvement. To ensure formal QIPs addressed actionable areas in need of improvement, MCPs were required to submit QIP topic proposals to DHCS for review and approval prior to the MCPs developing the formal QIP. For MCPs with multiple years of poor performance on several measures, DHCS required evidence of efforts to address the poor performance. Lastly, DHCS's auto-assignment program offers an increased incentive for MCPs in the TPM and GMC model to perform well by rewarding higher-performing MCPs with increased default membership.

Based on the review of the 2014 HEDIS results, HSAG provides the following recommendations to DHCS to support the MCPs in their continued efforts to improve their performance on measures:

- ◆ Continue to engage in intensive oversight of MCPs with poor performance on measures over consecutive years. Specifically, require the MCPs to develop corrective action plans and monitor quarterly, at minimum, to ensure the MCPs are engaging in rapid cycle improvement methods to improve performance on measures.
- ◆ Implement performance metrics around encounter data submission for the MCPs to improve data completeness.
- ◆ Consider progressive penalties for MCPs with continued or consecutive poor performance in one or more performance measure areas.
- ◆ Consider adding measures that fall below the MPLs to the auto-assignment algorithm as an incentive for MCPs to accelerate improvement.
- ◆ Continue to work with MCPs to ensure improvement plans for measures with rates below the MPLs include rapid cycle improvement strategies.
- ◆ Identify State-level barriers and develop strategies for addressing the barriers.

Appendix A. 2013 Hybrid Stratification Methodology for Reporting the Comprehensive Diabetes Care Measure

Medi-Cal Managed Care Division (MMCD) established a stratification methodology to be used for the *Comprehensive Diabetes Care* hybrid measure.

Managed care plans should use the following sampling method to determine the three denominators to be used to calculate distinct rates for the *Comprehensive Diabetes Care* measure for each county:

- ◆ The overall county rate.
- ◆ The Seniors and Persons with Disabilities (SPD) population rate.
- ◆ The non-SPD population rate.

See the illustrative example below assuming a required sample size of 411 for a hybrid measure:

Table A.1—Health Plan Sampling Method

Sample	Selection Process	Example
1	Select the required number of member medical records from Medi-Cal at large (the NCQA-required sample size). This will include members in both the SPD and non-SPD populations. Determine the number of members in each of the populations (SPD and non-SPD) that constitute Sample #1.	Assume a random sample of 411 cases is selected with the following distribution: 200 SPD members 211 non-SPD members
2A	Supplement the SPD sample population with additional SPD member records to reach the required sample size in #1.	200 SPD members + 211 additional SPD members = 411 SPD members
2B	Supplement the non-SPD sample population with additional non-SPD member records to reach the required sample size in #1.	211 non-SPD members + 200 additional non-SPD members = 411 non-SPD members
		822 Total Member Records

Sample #1 will be the denominator for the health plan's HEDIS submission.

Sample #2A is the SPD population denominator.

Sample #2B is the non-SPD population denominator.

Sample #2A and #2B will be reported on a template provided by MMCD.

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

– = A year that data were not collected.

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

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the “2013–14 Rate Difference” column in Tables B.1 through B.46. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲ ▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 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.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

For most measures, the reported rate will be bolded if it is below the national Medicaid 25th percentile, i.e., the minimum performance level (MPL), and will be shaded if it is above the 90th percentile, i.e., the high performance level (HPL) for that year. For the *Comprehensive Diabetes*

Care—HbA1c Poor Control measure, the reported rate will be bolded if it is above the 75th percentile and will be shaded if it is below the 10th percentile, since a lower rate indicates better performance.

Note:

- ◆ No MPL or HPL is established for the *All-Cause Readmissions* and *Ambulatory Care* measures; therefore, there is no bolding or shading of these measures' rates.
- ◆ Although the trend tables reflect if rates are below the MPL and above the HPL for all years included in the tables, MCPs are not held to the MPLs in the following cases: (1) for first-year measures, (2) for measures that had significant specification changes impacting comparability, or (3) if DHCS decided to prioritize efforts in other areas of poor performance. HSAG's analysis in this report accounts for years in which the MCPs were not held to the MPLs.

Table B.1—HEDIS 2014 Trend Table for Alameda Alliance for Health—Alameda County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.66%	17.42%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	42.02	47.24	29.28	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	315.03	297.17	240.12	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	87.05%	84.40%	83.78%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	86.41%	94.08%	93.43%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	84.78%	81.92%	84.34%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	35.61%	31.53%	38.09%	40.90%	↔
Cervical Cancer Screening	—	—	—	59.85%	Not Comparable
Childhood Immunization Status—Combination 3	47.92%	78.10%	79.08%	67.40%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.63%	92.32%	94.34%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	85.48%	83.91%	85.10%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	85.61%	85.06%	87.07%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	82.03%	84.64%	83.24%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	55.65%	59.85%	59.61%	57.66%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	40.00%	52.55%	48.91%	45.26%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.00%	83.21%	83.45%	81.75%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	40.00%	58.88%	51.58%	48.18%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.09%	43.55%	36.74%	29.20%	↓
Comprehensive Diabetes Care—LDL-C Screening	74.26%	76.89%	77.62%	71.29%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.74%	82.97%	82.97%	80.05%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	49.91%	28.47%	37.47%	51.82%	▼
Controlling High Blood Pressure	—	—	53.53%	45.99%	↓
Immunizations for Adolescents—Combination 1	—	66.67%	76.40%	79.08%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	43.88%	41.69%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	24.23%	17.80%	↓
Prenatal and Postpartum Care—Postpartum Care	58.84%	61.07%	57.18%	49.39%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	64.65%	88.56%	80.54%	79.56%	↔
Use of Imaging Studies for Low Back Pain	84.26%	84.76%	87.07%	88.58%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	39.58%	55.23%	55.23%	59.61%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	80.09%	58.64%	64.72%	71.29%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	55.79%	41.61%	46.23%	61.31%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.75%	77.62%	71.53%	70.80%	↔

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

Table B.2—HEDIS 2014 Trend Table for Anthem Blue Cross Partnership Plan—Alameda County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.67%	18.16%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	55.63	68.25	67.55	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	215.86	154.77	212.17	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	79.35%	77.02%	81.73%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	72.88%	73.14%	80.81%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	34.31%	39.13%	42.36%	33.83%	↔
Cervical Cancer Screening	—	—	—	49.18%	Not Comparable
Childhood Immunization Status—Combination 3	66.91%	70.56%	71.29%	71.30%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	93.51%	84.39%	85.16%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	82.89%	67.77%	77.82%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	84.12%	79.12%	78.58%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	79.44%	77.65%	75.18%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	50.61%	47.45%	35.92%	38.41%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	27.98%	35.28%	34.22%	35.10%	↔
Comprehensive Diabetes Care—HbA1c Testing	72.75%	73.48%	63.83%	75.94%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	37.71%	32.36%	30.58%	26.05%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.20%	22.38%	18.45%	17.66%	↔
Comprehensive Diabetes Care—LDL-C Screening	68.37%	66.91%	55.83%	61.37%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.86%	68.86%	71.36%	73.95%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	53.53%	60.58%	63.35%	67.55%	↔
Controlling High Blood Pressure	—	—	30.66%	34.15%	↔
Immunizations for Adolescents—Combination 1	—	64.96%	73.16%	73.04%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	42.61%	44.30%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	20.87%	21.94%	↔
Prenatal and Postpartum Care—Postpartum Care	51.09%	50.61%	36.74%	50.23%	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	65.94%	72.99%	75.18%	73.95%	↔
Use of Imaging Studies for Low Back Pain	86.88%	91.46%	90.20%	88.04%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	46.96%	44.04%	62.29%	46.17%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	55.23%	62.04%	61.07%	47.33%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	28.47%	31.14%	37.47%	40.84%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	62.04%	73.71%	57.32%	65.51%	↑

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

Table B.3—HEDIS 2014 Trend Table for Anthem Blue Cross Partnership Plan—Contra Costa County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	18.62%	17.30%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	52.2	61.62	62.60	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	213.84	202.66	234.67	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	76.67%	77.90%	80.33%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	67.86%	71.53%	75.90%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	30.00%	NA	54.29%	42.42%	↔
Cervical Cancer Screening	—	—	—	53.94%	Not Comparable
Childhood Immunization Status—Combination 3	68.61%	68.37%	76.16%	75.46%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	93.04%	96.93%	95.12%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	82.73%	85.01%	86.44%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	80.01%	85.18%	88.29%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	80.28%	82.76%	84.96%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	55.20%	46.72%	50.99%	46.13%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	26.40%	36.50%	38.61%	37.64%	↔
Comprehensive Diabetes Care—HbA1c Testing	69.60%	67.15%	69.31%	75.28%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	35.20%	29.20%	39.60%	36.16%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	26.40%	16.79%	29.21%	29.52%	↔
Comprehensive Diabetes Care—LDL-C Screening	61.60%	57.66%	64.36%	67.16%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	66.40%	64.96%	67.33%	78.60%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	58.40%	65.69%	52.97%	56.83%	↔
Controlling High Blood Pressure	—	—	46.15%	43.88%	↔
Immunizations for Adolescents—Combination 1	—	65.02%	68.35%	65.30%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	40.34%	40.74%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	18.18%	21.60%	↔
Prenatal and Postpartum Care—Postpartum Care	43.55%	48.15%	44.64%	44.26%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	69.35%	76.30%	79.46%	72.95%	↔
Use of Imaging Studies for Low Back Pain	85.92%	92.59%	81.48%	S	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	49.15%	42.58%	57.66%	50.00%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	52.80%	53.77%	52.31%	55.09%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	35.28%	25.55%	36.74%	47.92%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	63.26%	67.45%	63.93%	75.83%	↑

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

Table B.4—HEDIS 2014 Trend Table for Anthem Blue Cross Partnership Plan—Fresno County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.83%	14.38%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	43.10	48.83	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	247.54	236.16	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	80.77%	82.80%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	81.48%	82.63%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	30.68%	—	29.65%	33.76%	↔
Cervical Cancer Screening	—	—	—	50.93%	Not Comparable
Childhood Immunization Status—Combination 3	60.34%	—	70.80%	67.36%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	94.35%	93.76%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	82.85%	83.38%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	80.34%	83.51%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	76.54%	79.14%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.27%	—	58.74%	52.44%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	34.88%	—	38.35%	44.89%	↔
Comprehensive Diabetes Care—HbA1c Testing	79.76%	—	77.18%	79.33%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	36.10%	—	41.99%	36.22%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.05%	—	32.77%	30.89%	↔
Comprehensive Diabetes Care—LDL-C Screening	75.12%	—	71.84%	74.89%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.02%	—	77.43%	80.22%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	54.39%	—	50.24%	50.00%	↔
Controlling High Blood Pressure	—	—	50.85%	53.32%	↔
Immunizations for Adolescents—Combination 1	—	—	70.80%	68.22%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	35.29%	33.16%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	14.10%	15.57%	↔
Prenatal and Postpartum Care—Postpartum Care	50.85%	—	54.74%	52.90%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	70.56%	—	79.56%	74.94%	↔
Use of Imaging Studies for Low Back Pain	80.58%	—	84.06%	82.85%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	47.20%	—	58.88%	54.29%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	53.04%	—	63.02%	59.86%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	36.25%	—	46.23%	49.65%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.72%	—	67.88%	79.63%	↑

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

Table B.5—HEDIS 2014 Trend Table for Anthem Blue Cross Partnership Plan—Kings County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	16.58%	8.43%	▲
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	68.85	68.06	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	368.80	320.37	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	85.71%	81.64%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	84.56%	77.36%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	28.57%	32.69%	↔
Cervical Cancer Screening	—	—	—	56.05%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	66.77%	68.51%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	95.06%	94.74%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	86.53%	83.25%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	84.78%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	84.64%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	58.44%	54.39%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	38.31%	40.35%	↔
Comprehensive Diabetes Care—HbA1c Testing	—	—	75.00%	72.51%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	38.64%	25.73%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	25.97%	19.59%	↔
Comprehensive Diabetes Care—LDL-C Screening	—	—	73.05%	68.42%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	73.38%	77.19%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	—	—	55.19%	64.91%	▼
Controlling High Blood Pressure	—	—	43.55%	43.30%	↔
Immunizations for Adolescents—Combination 1	—	—	56.12%	69.66%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	40.22%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	16.30%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	54.37%	45.70%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	86.11%	80.08%	↔
Use of Imaging Studies for Low Back Pain	—	—	76.03%	84.30%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	46.47%	40.74%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	44.04%	43.29%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	31.39%	38.66%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	57.66%	65.05%	↑

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

Table B.6—HEDIS 2014 Trend Table for Anthem Blue Cross Partnership Plan—Madera County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	10.87%	8.63%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	59.71	58.44	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	313.66	293.80	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	76.60%	84.36%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics Annual Monitoring for Patients on Persistent Medications-Diuretics	—	—	78.26%	78.64%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	6.25%	20.00%	↔
Cervical Cancer Screening	—	—	—	60.19%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	76.40%	63.78%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	97.83%	98.47%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	88.53%	90.94%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	90.80%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	88.72%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	66.81%	61.09%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	55.02%	54.91%	↔
Comprehensive Diabetes Care—HbA1c Testing	—	—	84.72%	84.36%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	51.97%	43.27%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	31.44%	29.09%	↔
Comprehensive Diabetes Care—LDL-C Screening	—	—	72.93%	69.09%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	79.04%	80.73%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	—	—	36.24%	47.64%	▼
Controlling High Blood Pressure	—	—	53.36%	53.36%	↔
Immunizations for Adolescents—Combination 1	—	—	67.29%	72.62%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	29.66%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	16.95%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	51.57%	59.89%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	76.10%	77.47%	↔
Use of Imaging Studies for Low Back Pain	—	—	70.10%	83.54%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	77.62%	56.94%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	70.07%	61.81%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	48.66%	52.55%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	80.29%	86.81%	↑

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

Table B.7—HEDIS 2014 Trend Table for Anthem Blue Cross Partnership Plan—Sacramento County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	12.63%	11.83%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	41.3	53.18	53.51	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	210.8	210.46	216.69	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	61.68%	65.15%	80.33%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	86.11%	87.80%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	61.75%	67.21%	80.50%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.10%	24.14%	31.29%	27.54%	↔
Cervical Cancer Screening	—	—	—	50.70%	Not Comparable
Childhood Immunization Status—Combination 3	57.66%	57.42%	62.77%	58.80%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.51%	93.16%	94.03%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	81.91%	80.19%	81.58%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	81.22%	81.14%	80.92%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	80.23%	80.56%	78.14%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	54.99%	56.20%	57.04%	50.11%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	28.22%	32.36%	28.16%	37.75%	↑
Comprehensive Diabetes Care—HbA1c Testing	76.40%	76.16%	75.24%	75.28%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	43.55%	49.15%	46.12%	40.18%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.68%	25.79%	27.18%	29.36%	↔
Comprehensive Diabetes Care—LDL-C Screening	64.48%	62.04%	67.23%	64.68%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.02%	71.53%	71.60%	79.47%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	47.93%	42.58%	47.09%	47.68%	↔
Controlling High Blood Pressure	—	—	47.45%	48.11%	↔
Immunizations for Adolescents—Combination 1	—	51.58%	61.80%	62.62%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	44.31%	49.21%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	21.54%	30.61%	↑
Prenatal and Postpartum Care—Postpartum Care	49.88%	54.26%	47.92%	49.88%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	70.32%	76.89%	78.73%	72.39%	↓
Use of Imaging Studies for Low Back Pain	83.69%	84.94%	84.34%	83.20%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	49.88%	63.02%	65.45%	61.11%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	59.61%	71.29%	69.34%	63.43%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	27.74%	39.42%	44.53%	47.45%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.72%	64.33%	67.37%	70.83%	↔

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

Table B.8—HEDIS 2014 Trend Table for Anthem Blue Cross Partnership Plan—San Francisco County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.19%	16.67%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	38.76	52.12	58.29	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	250.78	275.35	293.45	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	80.10%	82.57%	84.48%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	79.10%	81.99%	84.19%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	50.00%	50.53%	53.25%	53.49%	↔
Cervical Cancer Screening	—	—	—	54.80%	Not Comparable
Childhood Immunization Status—Combination 3	79.08%	72.41%	74.68%	74.70%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.41%	96.11%	96.63%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	90.78%	86.94%	89.05%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	91.67%	90.85%	89.23%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	89.56%	89.58%	88.40%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	75.37%	62.33%	61.80%	56.44%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	46.31%	51.63%	45.26%	49.78%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.24%	83.72%	86.13%	82.00%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	55.67%	53.49%	52.55%	44.44%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	35.96%	37.67%	39.17%	32.00%	↓
Comprehensive Diabetes Care—LDL-C Screening	75.37%	69.77%	75.91%	70.44%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.77%	80.00%	85.89%	82.67%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	32.51%	33.95%	36.01%	47.56%	▼
Controlling High Blood Pressure	—	—	51.82%	48.45%	↔
Immunizations for Adolescents—Combination 1	—	69.42%	68.02%	76.52%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	38.20%	42.61%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	17.98%	25.22%	↔
Prenatal and Postpartum Care—Postpartum Care	55.50%	64.02%	64.85%	56.55%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.96%	85.71%	88.48%	77.38%	↓
Use of Imaging Studies for Low Back Pain	85.37%	80.39%	86.73%	89.11%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	53.53%	73.24%	60.06%	78.47%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	70.80%	79.32%	72.99%	75.00%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	56.20%	71.78%	65.52%	68.06%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.40%	80.00%	79.26%	80.55%	↔

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

Table B.9—HEDIS 2014 Trend Table for Anthem Blue Cross Partnership Plan—Santa Clara County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.74%	13.75%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	37.89	41.51	47.16	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	232.42	254.81	257.20	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	84.95%	86.63%	87.64%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	84.21%	86.61%	85.77%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	28.83%	20.00%	27.20%	28.24%	↔
Cervical Cancer Screening	—	—	—	62.56%	Not Comparable
Childhood Immunization Status—Combination 3	70.56%	66.91%	74.94%	67.82%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.63%	95.81%	95.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	86.67%	87.39%	87.49%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	87.63%	88.05%	89.72%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	86.34%	87.62%	85.64%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	72.51%	65.69%	58.50%	44.15%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.77%	64.48%	49.76%	45.25%	↔
Comprehensive Diabetes Care—HbA1c Testing	87.35%	85.89%	79.85%	83.00%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	60.10%	61.31%	53.88%	45.03%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.72%	47.20%	35.44%	40.40%	↔
Comprehensive Diabetes Care—LDL-C Screening	84.67%	82.73%	76.94%	80.35%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.97%	79.56%	80.10%	80.13%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	31.87%	29.44%	39.08%	43.27%	↔
Controlling High Blood Pressure	—	—	46.72%	40.93%	↔
Immunizations for Adolescents—Combination 1	—	60.10%	68.86%	72.45%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	43.37%	43.67%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	28.11%	24.90%	↔
Prenatal and Postpartum Care—Postpartum Care	65.69%	60.64%	56.20%	60.65%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.45%	79.52%	76.71%	80.09%	↔
Use of Imaging Studies for Low Back Pain	83.92%	82.43%	83.67%	80.35%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	65.69%	53.28%	55.23%	48.15%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	63.50%	70.56%	65.94%	46.99%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	35.52%	38.44%	50.36%	34.49%	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.07%	76.72%	76.72%	74.45%	↔

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

Table B.10—HEDIS 2014 Trend Table for Anthem Blue Cross Partnership Plan—Tulare County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	11.70%	10.59%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	25.62	42.20	42.71	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	194.99	293.82	325.32	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	70.48%	78.55%	85.06%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	69.03%	81.57%	84.53%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	15.85%	20.19%	19.52%	23.42%	↔
Cervical Cancer Screening	—	—	—	63.43%	Not Comparable
Childhood Immunization Status—Combination 3	69.10%	64.96%	71.78%	72.22%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	92.51%	92.47%	97.75%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	71.01%	82.72%	90.35%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	81.80%	79.60%	88.21%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	82.21%	82.20%	87.52%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	64.96%	68.13%	68.45%	54.97%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	29.20%	33.09%	35.68%	47.02%	↑
Comprehensive Diabetes Care—HbA1c Testing	77.13%	77.13%	78.40%	83.00%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	42.09%	45.26%	48.54%	42.60%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	31.87%	33.09%	32.52%	29.36%	↔
Comprehensive Diabetes Care—LDL-C Screening	69.83%	68.61%	69.66%	73.07%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.89%	77.62%	81.55%	81.46%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	49.64%	45.74%	43.69%	46.36%	↔
Controlling High Blood Pressure	—	—	53.28%	52.99%	↔
Immunizations for Adolescents—Combination 1	—	57.91%	70.97%	78.70%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	38.07%	43.12%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	18.88%	21.05%	↔
Prenatal and Postpartum Care—Postpartum Care	63.99%	53.13%	55.96%	58.24%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.73%	83.07%	76.16%	82.37%	↑
Use of Imaging Studies for Low Back Pain	79.56%	80.85%	81.07%	85.90%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	32.60%	83.94%	81.51%	65.28%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	48.91%	68.13%	64.23%	57.18%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	30.17%	50.36%	47.93%	47.92%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.24%	71.95%	64.91%	71.93%	↑

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

Table B.11—HEDIS 2014 Trend Table for CalOptima—Orange County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	16.69%	15.22%	▲
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	36.79	36.08	34.90	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	351.89	330.09	271.66	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	90.25%	90.75%	90.55%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	90.38%	93.54%	89.69%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	89.29%	90.65%	89.62%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	21.77%	20.73%	21.81%	20.65%	↔
Cervical Cancer Screening	—	—	—	71.63%	Not Comparable
Childhood Immunization Status—Combination 3	84.52%	81.30%	84.25%	79.40%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	97.67%	97.34%	97.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	92.55%	91.12%	91.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	92.05%	91.64%	92.30%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	90.37%	90.41%	89.07%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	70.37%	73.76%	73.95%	69.30%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	61.66%	69.25%	66.05%	67.91%	↔
Comprehensive Diabetes Care—HbA1c Testing	86.06%	86.45%	82.33%	85.12%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	61.22%	58.71%	56.98%	59.07%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	48.15%	50.75%	40.23%	49.77%	↑
Comprehensive Diabetes Care—LDL-C Screening	84.53%	85.59%	80.70%	84.88%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.22%	85.38%	83.02%	85.81%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	28.54%	30.97%	37.21%	32.33%	↔
Controlling High Blood Pressure	—	—	64.64%	67.25%	↔
Immunizations for Adolescents—Combination 1	—	69.21%	80.86%	84.15%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	48.71%	50.10%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	25.60%	28.33%	↑
Prenatal and Postpartum Care—Postpartum Care	72.37%	69.38%	63.66%	58.96%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.79%	84.82%	78.42%	85.07%	↑
Use of Imaging Studies for Low Back Pain	77.18%	79.00%	78.34%	75.25%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	72.35%	76.92%	81.39%	75.68%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	76.30%	81.43%	82.78%	84.19%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	68.15%	71.62%	75.56%	72.64%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	82.52%	82.54%	86.69%	83.94%	↔

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

Table B.12—HEDIS 2014 Trend Table for CalViva Health—Fresno County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	10.64%	13.10%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	45.57	50.13	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	448.77	469.48	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	82.27%	84.64%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	86.60%	80.77%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	83.02%	84.96%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	38.41%	38.66%	↔
Cervical Cancer Screening	—	—	—	64.34%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	76.89%	71.80%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	97.82%	96.60%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	91.50%	91.08%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	91.74%	91.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	90.68%	87.51%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	48.66%	54.26%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	48.91%	48.42%	↔
Comprehensive Diabetes Care—HbA1c Testing	—	—	82.97%	79.81%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	43.80%	38.20%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	36.74%	32.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	—	—	76.64%	72.99%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	75.67%	76.89%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	—	—	47.45%	54.74%	▼
Controlling High Blood Pressure	—	—	58.88%	53.12%	↔
Immunizations for Adolescents—Combination 1	—	—	76.89%	72.46%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	70.53%	44.11%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	43.01%	24.31%	↓
Prenatal and Postpartum Care—Postpartum Care	—	—	63.75%	61.20%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	90.02%	88.02%	↔
Use of Imaging Studies for Low Back Pain	—	—	82.11%	79.90%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	69.10%	64.96%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	71.29%	74.94%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	44.53%	52.55%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	81.51%	82.69%	↔

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

Table B.13—HEDIS 2014 Trend Table for CalViva Health—Kings County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	10.31%	7.92%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	60.31	62.09	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	452.56	430.69	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	80.23%	87.21%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	78.03%	84.25%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	32.14%	17.24%	↔
Cervical Cancer Screening	—	—	—	57.18%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	69.83%	70.06%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	96.98%	94.68%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	89.73%	83.58%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	87.06%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	84.62%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	50.36%	45.50%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	42.82%	48.42%	↔
Comprehensive Diabetes Care—HbA1c Testing	—	—	80.54%	78.59%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	41.85%	39.66%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	27.98%	32.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	—	—	74.94%	74.21%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	78.35%	78.10%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	—	—	50.85%	52.07%	↔
Controlling High Blood Pressure	—	—	55.23%	41.03%	↓
Immunizations for Adolescents—Combination 1	—	—	73.59%	73.20%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	48.59%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	30.51%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	57.46%	52.84%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	89.93%	82.67%	↓
Use of Imaging Studies for Low Back Pain	—	—	75.50%	80.23%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	48.42%	37.47%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	53.28%	45.99%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	41.36%	36.98%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	67.40%	59.29%	↓

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

Table B.14—HEDIS 2014 Trend Table for CalViva Health—Madera County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	10.81%	13.40%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	50.89	52.05	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	444.01	482.26	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	80.80%	83.06%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	81.88%	85.94%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	25.61%	16.67%	↔
Cervical Cancer Screening	—	—	—	64.44%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	71.29%	66.96%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	98.53%	98.08%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	91.75%	93.49%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	92.88%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	90.68%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	59.37%	64.96%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	55.72%	60.34%	↔
Comprehensive Diabetes Care—HbA1c Testing	—	—	85.89%	88.32%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	46.47%	43.07%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	33.09%	34.31%	↔
Comprehensive Diabetes Care—LDL-C Screening	—	—	70.32%	74.45%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	81.27%	82.00%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	—	—	43.31%	49.39%	↔
Controlling High Blood Pressure	—	—	56.69%	52.10%	↔
Immunizations for Adolescents—Combination 1	—	—	65.66%	69.68%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	42.78%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	24.23%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	65.90%	50.27%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	93.35%	80.05%	↓
Use of Imaging Studies for Low Back Pain	—	—	77.17%	70.68%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	62.29%	59.28%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	73.72%	68.81%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	64.72%	60.82%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	84.43%	87.34%	↔

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

Table B.15—HEDIS 2014 Trend Table for Care1st Partner Plan—San Diego County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	15.64%	15.57%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	48.06	50.84	51.00	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	239.46	291.33	279.31	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	89.19%	81.79%	83.72%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	86.76%	80.19%	83.96%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	28.00%	15.38%	20.83%	27.41%	↔
Cervical Cancer Screening	—	—	—	43.31%	Not Comparable
Childhood Immunization Status—Combination 3	79.81%	73.24%	72.75%	65.45%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	90.56%	93.54%	89.27%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	78.47%	82.76%	80.91%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	81.48%	82.67%	80.88%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	77.75%	81.15%	78.71%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	66.06%	73.90%	58.39%	46.72%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.82%	47.39%	40.39%	37.71%	↔
Comprehensive Diabetes Care—HbA1c Testing	83.64%	88.76%	84.91%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	52.73%	49.00%	51.82%	42.58%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.06%	38.15%	37.23%	32.36%	↔
Comprehensive Diabetes Care—LDL-C Screening	80.61%	81.53%	78.59%	72.99%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	87.27%	88.35%	85.40%	82.24%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	30.91%	36.95%	42.09%	51.82%	▼
Controlling High Blood Pressure	—	—	51.71%	42.82%	↓
Immunizations for Adolescents—Combination 1	—	62.13%	70.26%	67.88%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	40.59%	54.55%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	24.75%	37.01%	↑
Prenatal and Postpartum Care—Postpartum Care	60.45%	67.06%	59.18%	60.58%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.00%	85.00%	81.12%	81.02%	↔
Use of Imaging Studies for Low Back Pain	61.02%	82.72%	70.00%	72.11%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	57.18%	65.94%	74.45%	54.99%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	63.26%	68.37%	72.26%	62.29%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	36.25%	46.72%	51.58%	37.96%	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.79%	73.44%	67.07%	67.34%	↔

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

Table B.16—HEDIS 2014 Trend Table for CenCal Health—San Luis Obispo County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.49%	12.28%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	65.82	63.56	58.78	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	343.58	346.43	334.76	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	82.95%	81.02%	80.16%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	82.35%	84.20%	84.92%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	34.44%	33.33%	14.46%	17.24%	↔
Cervical Cancer Screening	—	—	—	62.77%	Not Comparable
Childhood Immunization Status—Combination 3	76.32%	76.39%	78.03%	77.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.17%	95.31%	96.78%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	87.31%	86.21%	89.60%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	88.32%	87.64%	90.47%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	86.08%	86.69%	86.83%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	66.91%	67.64%	70.56%	65.94%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	60.83%	61.56%	58.39%	59.12%	↔
Comprehensive Diabetes Care—HbA1c Testing	73.72%	81.02%	82.00%	84.18%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	51.34%	59.37%	61.31%	58.15%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.69%	41.36%	42.58%	40.15%	↔
Comprehensive Diabetes Care—LDL-C Screening	75.43%	78.59%	79.56%	79.08%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.32%	84.67%	82.73%	85.40%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.12%	32.60%	31.14%	30.90%	↔
Controlling High Blood Pressure	—	—	63.02%	54.43%	↓
Immunizations for Adolescents—Combination 1	—	60.10%	71.65%	65.79%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	42.34%	45.28%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	26.28%	26.77%	↔
Prenatal and Postpartum Care—Postpartum Care	70.42%	70.11%	71.04%	70.47%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.51%	82.76%	87.43%	87.13%	↔
Use of Imaging Studies for Low Back Pain	78.38%	77.86%	75.69%	80.89%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	46.96%	62.29%	64.23%	77.13%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	57.91%	59.61%	61.31%	60.10%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	34.79%	47.69%	50.36%	51.82%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	63.66%	69.79%	67.97%	72.95%	↔

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

Table B.17—HEDIS 2014 Trend Table for CenCal Health—Santa Barbara County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	11.13%	13.15%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	48.37	52.16	51.43	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	346.64	335.52	301.90	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	86.89%	84.72%	85.79%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	86.11%	84.85%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	87.25%	85.46%	86.74%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	31.61%	29.55%	19.13%	22.62%	↔
Cervical Cancer Screening	—	—	—	74.45%	Not Comparable
Childhood Immunization Status—Combination 3	82.31%	85.20%	85.84%	83.56%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	97.31%	97.84%	98.49%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	90.42%	91.16%	93.58%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	89.69%	90.88%	92.88%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	87.69%	89.29%	90.59%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	69.59%	69.10%	74.21%	72.02%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.32%	71.29%	70.56%	68.61%	↔
Comprehensive Diabetes Care—HbA1c Testing	81.75%	92.21%	83.94%	86.37%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	61.56%	69.34%	59.61%	59.37%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	45.74%	50.12%	38.93%	40.39%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.89%	85.16%	80.54%	80.05%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.56%	87.35%	82.48%	84.91%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	28.95%	22.63%	33.58%	31.87%	↔
Controlling High Blood Pressure	—	—	60.58%	60.25%	↔
Immunizations for Adolescents—Combination 1	—	70.07%	78.74%	80.90%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	47.38%	50.28%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	27.67%	26.70%	↔
Prenatal and Postpartum Care—Postpartum Care	77.57%	76.35%	73.44%	76.83%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.49%	80.74%	81.64%	85.98%	↔
Use of Imaging Studies for Low Back Pain	80.67%	80.46%	80.57%	81.72%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	59.12%	66.42%	70.56%	74.21%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	72.51%	67.88%	72.75%	72.99%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	39.17%	44.77%	51.34%	57.66%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.39%	76.01%	79.34%	80.65%	↔

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

Table B.18—HEDIS 2014 Trend Table for Central California Alliance for Health—Merced County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	12.73%	12.78%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	49.09	53.69	52.70	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	320.62	324.06	321.41	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	86.41%	87.14%	86.87%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	83.33%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	87.31%	86.97%	86.43%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	15.09%	11.61%	16.23%	18.62%	↔
Cervical Cancer Screening	—	—	—	65.63%	Not Comparable
Childhood Immunization Status—Combination 3	55.23%	64.72%	64.74%	68.68%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.92%	97.42%	97.63%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	91.25%	90.39%	91.65%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	89.54%	89.82%	90.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	87.63%	90.19%	88.46%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	67.15%	64.48%	64.96%	62.53%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.61%	56.20%	54.74%	53.53%	↔
Comprehensive Diabetes Care—HbA1c Testing	86.13%	87.83%	84.91%	83.94%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.72%	51.34%	46.72%	44.28%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.01%	37.96%	33.09%	32.85%	↔
Comprehensive Diabetes Care—LDL-C Screening	80.05%	80.29%	80.54%	78.59%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.37%	82.48%	84.91%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	44.04%	37.23%	45.99%	45.74%	↔
Controlling High Blood Pressure	—	—	52.80%	53.66%	↔
Immunizations for Adolescents—Combination 1	—	50.12%	55.96%	64.86%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	48.30%	54.14%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	26.16%	29.04%	↔
Prenatal and Postpartum Care—Postpartum Care	63.02%	59.61%	58.79%	60.35%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.32%	85.40%	83.92%	82.79%	↔
Use of Imaging Studies for Low Back Pain	79.87%	84.15%	79.33%	82.49%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	46.72%	58.88%	77.62%	82.24%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	62.29%	64.23%	66.91%	68.13%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	40.39%	44.28%	44.77%	43.07%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.97%	72.51%	74.33%	76.32%	↔

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

**Table B.19—HEDIS 2014 Trend Table for Central California Alliance for Health—
Monterey/Santa Cruz Counties**

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	12.06%	11.58%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	51.95	52.10	46.64	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	320.58	318.74	303.75	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	88.31%	85.86%	87.34%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	87.93%	89.47%	87.76%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	88.95%	85.58%	87.02%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.36%	27.95%	22.27%	28.07%	↔
Cervical Cancer Screening	—	—	—	72.22%	Not Comparable
Childhood Immunization Status—Combination 3	82.73%	84.18%	83.84%	82.48%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	97.42%	98.49%	98.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	91.05%	91.29%	92.11%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	89.57%	90.89%	93.18%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	88.93%	91.00%	90.94%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	71.78%	76.64%	71.05%	75.18%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	65.94%	67.40%	63.02%	56.45%	↔
Comprehensive Diabetes Care—HbA1c Testing	89.05%	91.97%	87.35%	86.86%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.45%	61.80%	51.09%	51.82%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	45.74%	47.20%	39.66%	35.77%	↔
Comprehensive Diabetes Care—LDL-C Screening	84.43%	84.91%	78.83%	79.81%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.48%	79.81%	79.32%	79.32%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	33.33%	28.22%	36.98%	38.20%	↔
Controlling High Blood Pressure	—	—	55.96%	59.46%	↔
Immunizations for Adolescents—Combination 1	—	63.99%	77.60%	80.29%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	49.96%	52.98%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	24.42%	30.21%	↑
Prenatal and Postpartum Care—Postpartum Care	75.43%	77.62%	70.27%	69.83%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.43%	86.13%	81.76%	93.10%	↑
Use of Imaging Studies for Low Back Pain	86.06%	85.12%	88.00%	85.20%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	69.83%	79.08%	81.89%	81.02%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	72.26%	80.29%	81.63%	78.59%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	61.31%	61.31%	66.58%	65.21%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	83.45%	83.21%	82.08%	80.29%	↔

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

Table B.20—HEDIS 2014 Trend Table for Community Health Group Partnership Plan—San Diego County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.37%	13.28%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	32.73	37.42	36.42	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	329	310.89	293.39	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	87.07%	84.99%	87.41%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	91.23%	95.71%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	85.01%	85.04%	88.16%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	17.31%	14.08%	32.02%	39.69%	↑
Cervical Cancer Screening	—	—	—	65.21%	Not Comparable
Childhood Immunization Status—Combination 3	78.10%	73.97%	73.97%	70.07%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.21%	97.32%	95.95%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	90.27%	89.85%	89.92%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	89.61%	89.90%	89.41%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	88.45%	88.64%	85.47%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	65.69%	57.18%	64.72%	45.99%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	61.07%	53.28%	55.47%	55.47%	↔
Comprehensive Diabetes Care—HbA1c Testing	88.32%	87.35%	90.02%	86.13%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	52.31%	47.69%	56.45%	45.01%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	40.63%	35.04%	39.66%	39.66%	↔
Comprehensive Diabetes Care—LDL-C Screening	84.67%	82.24%	83.70%	81.75%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.21%	79.08%	83.21%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	37.71%	43.80%	34.31%	40.88%	↔
Controlling High Blood Pressure	—	—	52.07%	52.07%	↔
Immunizations for Adolescents—Combination 1	—	73.48%	79.32%	76.40%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	35.41%	47.09%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	18.66%	27.95%	↑
Prenatal and Postpartum Care—Postpartum Care	57.18%	60.10%	55.23%	57.91%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.08%	77.86%	82.24%	80.29%	↔
Use of Imaging Studies for Low Back Pain	77.75%	75.03%	79.24%	77.32%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	63.26%	73.48%	78.10%	87.59%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	69.83%	71.53%	71.29%	75.43%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	40.39%	55.96%	63.99%	70.32%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.95%	77.13%	77.86%	78.10%	↔

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

Table B.21—HEDIS 2014 Trend Table for Contra Costa Health Plan—Contra Costa County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	16.99%	12.95%	▲
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	59.47	60.94	53.25	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	274.88	217.23	246.81	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	85.62%	83.77%	86.52%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	85.71%	95.45%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	80.95%	83.68%	85.11%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	29.56%	26.52%	43.27%	44.09%	↔
Cervical Cancer Screening	—	—	—	54.99%	Not Comparable
Childhood Immunization Status—Combination 3	87.16%	85.40%	84.47%	74.70%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	93.97%	86.74%	94.62%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	84.54%	76.18%	86.07%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	84.07%	77.96%	86.71%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	83.25%	74.86%	83.44%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	55.11%	54.99%	59.37%	61.31%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	49.09%	52.80%	51.09%	51.34%	↔
Comprehensive Diabetes Care—HbA1c Testing	86.86%	84.91%	85.40%	84.43%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.57%	53.04%	49.88%	48.18%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	40.69%	36.25%	41.61%	42.34%	↔
Comprehensive Diabetes Care—LDL-C Screening	77.74%	75.43%	82.00%	75.67%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	89.23%	87.35%	82.00%	83.94%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	33.94%	36.98%	40.39%	41.61%	↔
Controlling High Blood Pressure	—	—	51.34%	53.28%	↔
Immunizations for Adolescents—Combination 1	—	59.85%	71.61%	73.24%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	56.90%	43.46%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	33.95%	22.79%	↓
Prenatal and Postpartum Care—Postpartum Care	67.40%	64.96%	62.53%	60.34%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	81.75%	83.21%	86.86%	83.45%	↔
Use of Imaging Studies for Low Back Pain	88.64%	88.58%	92.06%	87.85%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	61.07%	59.37%	56.20%	62.29%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	58.88%	55.72%	55.96%	59.37%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	46.47%	46.47%	46.23%	50.85%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.82%	77.86%	73.31%	74.45%	↔

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

Table B.22—HEDIS 2014 Trend Table for Gold Coast Health Plan—Ventura County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	19.17%	13.08%	▲
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	49.21	38.12	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	317.16	205.78	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	86.73%	88.47%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	88.46%	93.33%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	86.28%	89.51%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	13.87%	18.24%	↔
Cervical Cancer Screening	—	—	—	60.58%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	80.05%	75.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	82.51%	97.37%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	63.09%	86.27%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	82.26%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	79.18%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	62.29%	61.31%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	42.58%	45.74%	↔
Comprehensive Diabetes Care—HbA1c Testing	—	—	81.75%	85.16%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	37.96%	45.50%	↑
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	33.58%	28.47%	↔
Comprehensive Diabetes Care—LDL-C Screening	—	—	78.83%	79.56%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	79.81%	78.10%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	—	—	56.20%	45.50%	▲
Controlling High Blood Pressure	—	—	61.56%	54.01%	↓
Immunizations for Adolescents—Combination 1	—	—	65.21%	60.34%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	48.92%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	28.03%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	63.99%	59.37%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	80.78%	83.94%	↔
Use of Imaging Studies for Low Back Pain	—	—	76.95%	77.07%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	42.09%	43.80%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	42.09%	43.31%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	30.41%	28.71%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	61.80%	64.23%	↔

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

Table B.23—HEDIS 2014 Trend Table for Health Net Community Solutions, Inc.—Kern County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	10.40%	11.50%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	47.52	53.28	54.16	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	269.41	200.09	350.94	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	77.67%	75.85%	82.19%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	83.33%	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	79.57%	76.59%	81.82%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	18.18%	17.23%	26.00%	23.14%	↔
Cervical Cancer Screening	—	—	—	49.64%	Not Comparable
Childhood Immunization Status—Combination 3	70.44%	71.35%	68.71%	65.28%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	93.78%	89.78%	92.95%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	80.79%	70.48%	79.16%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	78.17%	68.16%	67.96%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	81.18%	76.57%	67.50%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58.41%	65.82%	50.12%	50.36%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.24%	54.04%	44.28%	42.34%	↔
Comprehensive Diabetes Care—HbA1c Testing	79.09%	78.52%	73.24%	76.89%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	40.63%	40.88%	38.20%	33.33%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.54%	35.57%	38.93%	35.52%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.44%	73.21%	72.75%	74.45%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.69%	83.14%	80.78%	79.32%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	48.80%	50.58%	52.80%	60.10%	▼
Controlling High Blood Pressure	—	—	51.34%	47.20%	↔
Immunizations for Adolescents—Combination 1	—	60.58%	71.90%	73.39%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	69.12%	55.20%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	51.47%	35.29%	↓
Prenatal and Postpartum Care—Postpartum Care	62.41%	62.41%	53.09%	54.15%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.29%	89.47%	78.87%	71.71%	↓
Use of Imaging Studies for Low Back Pain	73.50%	75.26%	73.53%	74.70%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	53.16%	55.28%	72.02%	78.65%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	69.66%	71.24%	81.02%	86.98%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	41.75%	51.24%	63.99%	77.86%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.02%	69.21%	65.54%	71.54%	↔

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

Table B.24—HEDIS 2014 Trend Table for Health Net Community Solutions, Inc.—Los Angeles County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	11.93%	11.64%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	33.03	36.51	35.29	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	241.22	251.36	274.97	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	74.03%	76.09%	80.35%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	76.99%	85.92%	86.38%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	74.07%	76.27%	80.78%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	20.18%	21.40%	40.16%	27.72%	↓
Cervical Cancer Screening	—	—	—	61.80%	Not Comparable
Childhood Immunization Status—Combination 3	77.10%	87.62%	81.63%	76.15%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.13%	94.29%	94.47%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	88.17%	81.11%	81.18%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	87.98%	83.12%	81.99%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	85.90%	82.82%	77.41%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.89%	67.53%	50.12%	59.61%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	55.32%	58.82%	47.69%	50.36%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.03%	83.53%	78.10%	79.81%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.30%	48.47%	39.90%	45.26%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.27%	37.41%	35.52%	37.23%	↔
Comprehensive Diabetes Care—LDL-C Screening	80.79%	76.47%	75.43%	77.62%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.57%	82.35%	82.97%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	40.74%	39.76%	48.42%	48.66%	↔
Controlling High Blood Pressure	—	—	57.91%	56.33%	↔
Immunizations for Adolescents—Combination 1	—	65.02%	73.67%	78.66%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	72.65%	53.36%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	49.52%	33.05%	↓
Prenatal and Postpartum Care—Postpartum Care	58.21%	52.34%	48.05%	45.01%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.57%	83.64%	73.41%	68.37%	↔
Use of Imaging Studies for Low Back Pain	80.02%	81.09%	78.01%	76.76%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	63.61%	71.53%	75.78%	70.35%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	71.33%	79.86%	80.73%	75.47%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	53.73%	63.66%	66.41%	67.65%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	79.10%	83.10%	77.08%	69.26%	↓

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

Table B.25—HEDIS 2014 Trend Table for Health Net Community Solutions, Inc.—Sacramento County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	12.15%	12.69%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	38.1	45.02	44.04	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	241	300.55	305.99	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	59.33%	67.16%	72.60%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	82.46%	84.75%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	55.59%	67.40%	70.56%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	28.48%	20.21%	51.66%	27.62%	↓
Cervical Cancer Screening	—	—	—	48.91%	Not Comparable
Childhood Immunization Status—Combination 3	67.33%	69.55%	66.67%	59.57%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.41%	92.53%	92.57%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	84.73%	80.19%	81.06%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	84.22%	80.69%	79.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	83.57%	81.64%	75.02%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.55%	62.91%	48.91%	45.99%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	45.62%	48.36%	40.63%	37.96%	↔
Comprehensive Diabetes Care—HbA1c Testing	83.82%	83.57%	77.86%	77.62%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	49.21%	52.82%	43.55%	48.18%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.75%	33.57%	35.77%	33.33%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.40%	73.94%	67.40%	67.64%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.57%	82.63%	83.45%	80.29%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	40.00%	35.92%	45.26%	46.23%	↔
Controlling High Blood Pressure	—	—	54.50%	45.72%	↓
Immunizations for Adolescents—Combination 1	—	54.61%	63.08%	62.76%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	78.74%	58.83%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	55.94%	40.03%	↓
Prenatal and Postpartum Care—Postpartum Care	60.57%	60.78%	53.16%	49.02%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.89%	83.58%	81.77%	77.07%	↔
Use of Imaging Studies for Low Back Pain	87.78%	87.52%	87.00%	85.49%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	67.88%	69.51%	77.32%	59.06%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	73.48%	77.58%	76.34%	72.95%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	41.61%	52.69%	57.07%	58.81%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.85%	78.20%	71.18%	67.54%	↔

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

Table B.26—HEDIS 2014 Trend Table for Health Net Community Solutions, Inc.—San Diego County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	15.96%	15.90%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	44.1	50.92	46.66	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	258.6	317.66	354.48	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	78.12%	83.68%	89.08%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	100.0%	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	77.56%	83.82%	88.33%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	18.12%	18.46%	44.85%	28.18%	↓
Cervical Cancer Screening	—	—	—	39.66%	Not Comparable
Childhood Immunization Status—Combination 3	69.82%	77.30%	72.30%	67.46%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.01%	93.98%	95.87%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	85.83%	85.27%	87.67%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	85.38%	84.91%	86.20%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	82.99%	82.51%	82.09%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	53.78%	64.38%	52.07%	46.23%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.43%	51.91%	45.99%	44.77%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.59%	84.48%	85.40%	77.13%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	41.99%	48.35%	50.85%	38.69%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	31.42%	35.62%	41.12%	30.90%	↓
Comprehensive Diabetes Care—LDL-C Screening	73.41%	76.34%	79.08%	70.32%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.18%	78.63%	82.24%	78.10%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	46.53%	41.48%	41.61%	54.01%	▼
Controlling High Blood Pressure	—	—	55.23%	44.72%	↓
Immunizations for Adolescents—Combination 1	—	65.29%	76.86%	66.23%	↓
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	75.28%	57.50%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	55.06%	40.00%	↓
Prenatal and Postpartum Care—Postpartum Care	62.47%	54.77%	53.75%	41.11%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.84%	83.38%	76.67%	62.78%	↓
Use of Imaging Studies for Low Back Pain	74.07%	77.40%	76.04%	64.79%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	51.34%	67.56%	72.99%	77.32%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	61.31%	67.78%	74.70%	74.59%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	43.07%	49.56%	67.15%	70.77%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.80%	70.00%	74.43%	76.64%	↔

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

Table B.27—HEDIS 2014 Trend Table for Health Net Community Solutions, Inc.—San Joaquin County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	—	18.60%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	—	53.47	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	—	266.70	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	—	67.00%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	—	65.45%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	—	NA	Not Comparable
Cervical Cancer Screening	—	—	—	20.92%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	—	92.11%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	—	76.97%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	—	34.96%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	—	39.02%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	—	—	73.17%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	—	29.27%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	—	28.46%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	—	—	60.16%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	—	81.30%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	—	—	—	65.04%	Not Comparable
Controlling High Blood Pressure	—	—	—	30.86%	Not Comparable
Immunizations for Adolescents—Combination 1	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	—	46.38%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	—	71.01%	Not Comparable
Use of Imaging Studies for Low Back Pain	—	—	—	NA	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	—	61.07%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	—	68.37%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	—	55.72%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	—	59.12%	Not Comparable

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

Table B.28—HEDIS 2014 Trend Table for Health Net Community Solutions, Inc.—Stanislaus County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	8.71%	10.97%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	49.38	55.13	62.40	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	349.91	369.94	392.65	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	75.91%	83.73%	83.17%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	79.78%	84.46%	84.38%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.51%	29.55%	32.31%	22.19%	↓
Cervical Cancer Screening	—	—	—	48.18%	Not Comparable
Childhood Immunization Status—Combination 3	67.80%	68.52%	71.67%	70.18%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	97.18%	97.04%	95.59%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	88.90%	87.15%	85.89%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	87.88%	85.24%	86.39%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	85.93%	86.00%	83.84%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	67.83%	67.30%	58.39%	58.64%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.70%	50.00%	41.61%	41.36%	↔
Comprehensive Diabetes Care—HbA1c Testing	82.03%	84.60%	88.32%	87.10%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	52.75%	53.08%	56.93%	51.82%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.39%	39.34%	34.55%	41.36%	↑
Comprehensive Diabetes Care—LDL-C Screening	75.36%	76.07%	78.59%	77.62%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.03%	77.01%	78.59%	78.35%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	37.10%	36.49%	31.87%	37.23%	↔
Controlling High Blood Pressure	—	—	56.20%	56.30%	↔
Immunizations for Adolescents—Combination 1	—	54.18%	65.77%	56.65%	↓
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	77.04%	57.78%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	52.55%	38.22%	↓
Prenatal and Postpartum Care—Postpartum Care	62.26%	60.10%	58.73%	55.61%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.16%	91.52%	91.90%	83.29%	↓
Use of Imaging Studies for Low Back Pain	77.57%	83.83%	83.22%	77.33%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	55.23%	58.68%	70.56%	66.83%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	63.26%	65.75%	65.69%	62.59%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	41.12%	40.18%	58.15%	66.08%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.60%	71.11%	70.47%	70.11%	↔

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

Table B.29—HEDIS 2014 Trend Table for Health Net Community Solutions, Inc.—Tulare County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	11.86%	11.74%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	39.3	41.73	42.27	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	386.74	467.09	505.10	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	83.59%	83.50%	84.77%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	91.43%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	79.73%	84.60%	84.10%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	17.54%	22.85%	26.14%	24.05%	↔
Cervical Cancer Screening	—	—	—	59.85%	Not Comparable
Childhood Immunization Status—Combination 3	76.32%	78.93%	78.47%	75.69%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	97.32%	97.76%	97.60%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	92.25%	92.37%	91.99%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	92.76%	91.72%	91.23%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	91.48%	93.05%	89.42%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	71.33%	67.45%	54.26%	55.96%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	56.40%	56.84%	41.85%	50.12%	↑
Comprehensive Diabetes Care—HbA1c Testing	86.49%	83.02%	86.62%	79.56%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.58%	47.88%	49.64%	45.26%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.23%	36.56%	36.50%	30.66%	↔
Comprehensive Diabetes Care—LDL-C Screening	77.49%	76.18%	77.86%	69.34%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.94%	82.78%	82.00%	79.56%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.71%	43.40%	43.55%	47.45%	↔
Controlling High Blood Pressure	—	—	54.01%	49.39%	↔
Immunizations for Adolescents—Combination 1	—	61.80%	78.32%	76.04%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	72.85%	52.92%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	47.68%	32.82%	↓
Prenatal and Postpartum Care—Postpartum Care	68.38%	67.93%	65.57%	57.98%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.21%	93.75%	90.16%	88.56%	↔
Use of Imaging Studies for Low Back Pain	73.08%	82.72%	80.00%	83.22%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	73.40%	77.57%	76.64%	65.94%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	66.75%	66.36%	66.42%	65.69%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	49.17%	45.33%	49.15%	49.88%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.25%	77.32%	73.31%	80.18%	↑

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

Table B.30—HEDIS 2014 Trend Table for Health Plan of San Joaquin—San Joaquin County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	7.07%	11.06%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	38.16	46.68	45.89	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	283.73	274.87	249.11	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	85.56%	83.69%	83.80%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	92.11%	94.12%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	85.05%	84.58%	84.29%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	27.13%	25.42%	29.24%	25.10%	↓
Cervical Cancer Screening	—	—	—	61.12%	Not Comparable
Childhood Immunization Status—Combination 3	74.45%	77.13%	76.40%	75.91%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.66%	97.49%	97.04%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	86.82%	87.59%	87.79%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	84.17%	85.71%	86.70%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	83.53%	84.94%	83.23%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	75.18%	77.62%	78.28%	65.69%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.31%	53.28%	45.62%	44.77%	↔
Comprehensive Diabetes Care—HbA1c Testing	80.54%	81.51%	80.66%	79.08%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	51.82%	55.96%	52.37%	51.82%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	31.39%	39.17%	35.22%	41.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	75.91%	78.59%	75.55%	75.18%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.16%	80.29%	82.12%	79.08%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.36%	36.74%	39.60%	40.15%	↔
Controlling High Blood Pressure	—	—	66.42%	65.45%	↔
Immunizations for Adolescents—Combination 1	—	63.99%	67.15%	72.02%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	40.72%	43.45%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	21.82%	23.04%	↔
Prenatal and Postpartum Care—Postpartum Care	65.21%	68.61%	64.48%	60.83%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.83%	88.08%	85.64%	82.24%	↔
Use of Imaging Studies for Low Back Pain	82.45%	80.67%	81.80%	84.03%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	67.15%	73.48%	69.10%	70.32%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	69.59%	72.51%	72.75%	68.37%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	58.15%	65.69%	61.80%	55.96%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.27%	80.54%	76.16%	76.89%	↔

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

Table B.31—HEDIS 2014 Trend Table for Health Plan of San Joaquin—Stanislaus County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	—	13.11%	Not Comparable
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	—	56.07	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	—	272.99	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	—	84.64%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	—	87.39%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	—	16.95%	Not Comparable
Cervical Cancer Screening	—	—	—	41.08%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	—	64.96%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	—	97.23%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	—	88.43%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	—	88.90%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	—	86.60%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	—	67.88%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	—	37.23%	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	—	—	—	85.40%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	—	52.31%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	—	40.63%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	—	—	—	74.94%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	—	80.29%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	—	—	—	36.98%	Not Comparable
Controlling High Blood Pressure	—	—	—	56.20%	Not Comparable
Immunizations for Adolescents—Combination 1	—	—	—	58.15%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	—	51.65%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	—	21.98%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	—	54.99%	Not Comparable
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	—	73.24%	Not Comparable
Use of Imaging Studies for Low Back Pain	—	—	—	76.51%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	—	54.01%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	—	41.85%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	—	39.17%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	—	68.61%	Not Comparable

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

Table B.32—HEDIS 2014 Trend Table for Health Plan of San Mateo—San Mateo County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.52%	15.68%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	51.62	52.11	48.80	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	483.04	546.12	445.65	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	89.28%	89.51%	90.97%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	92.71%	94.95%	94.34%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	89.85%	90.57%	91.85%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.49%	34.06%	34.46%	37.13%	↔
Cervical Cancer Screening	—	—	—	61.80%	Not Comparable
Childhood Immunization Status—Combination 3	83.67%	80.29%	75.56%	82.11%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.89%	96.70%	97.13%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	88.34%	88.32%	90.40%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	87.75%	89.36%	89.74%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	84.89%	85.61%	85.34%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.26%	66.18%	56.93%	46.72%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	59.85%	61.07%	57.42%	60.83%	↔
Comprehensive Diabetes Care—HbA1c Testing	86.62%	79.81%	83.70%	87.10%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	57.42%	55.72%	56.45%	54.01%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.96%	46.47%	46.96%	42.82%	↔
Comprehensive Diabetes Care—LDL-C Screening	84.18%	82.00%	80.78%	80.78%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.62%	87.83%	82.97%	90.02%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	34.06%	37.96%	35.28%	38.69%	↔
Controlling High Blood Pressure	—	—	51.34%	29.93%	↓
Immunizations for Adolescents—Combination 1	—	68.49%	70.28%	78.45%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	48.51%	50.21%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	26.38%	27.69%	↔
Prenatal and Postpartum Care—Postpartum Care	61.84%	61.22%	59.18%	59.55%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.16%	81.89%	84.18%	82.66%	↔
Use of Imaging Studies for Low Back Pain	84.62%	81.51%	80.07%	79.18%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	47.89%	66.67%	55.47%	67.32%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	75.43%	77.62%	70.05%	73.90%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	59.06%	63.99%	53.91%	63.66%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.44%	73.80%	77.13%	75.68%	↔

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

Table B.33—HEDIS 2014 Trend Table for Inland Empire Health Plan—Riverside/San Bernardino Counties

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.24%	14.73%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	49.54	51.67	48.50	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	326.35	347.94	288.05	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	84.22%	86.98%	86.33%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	89.45%	91.99%	90.80%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	83.53%	86.07%	85.42%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.88%	22.10%	22.53%	21.52%	↔
Cervical Cancer Screening	—	—	—	70.47%	Not Comparable
Childhood Immunization Status—Combination 3	69.44%	77.78%	78.24%	76.85%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.33%	96.75%	96.67%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	86.92%	86.91%	86.77%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	83.53%	83.18%	84.55%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	86.30%	86.72%	83.97%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	70.94%	75.76%	71.00%	62.88%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	42.31%	52.68%	59.40%	51.74%	↓
Comprehensive Diabetes Care—HbA1c Testing	79.49%	82.98%	85.61%	84.69%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.94%	48.72%	50.81%	46.87%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.39%	38.69%	42.00%	40.60%	↔
Comprehensive Diabetes Care—LDL-C Screening	79.70%	81.12%	83.53%	81.67%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.34%	83.68%	84.45%	82.13%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	43.80%	40.79%	36.19%	39.44%	↔
Controlling High Blood Pressure	—	—	62.91%	67.56%	↔
Immunizations for Adolescents—Combination 1	—	63.66%	71.99%	70.60%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	44.25%	52.09%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	21.96%	29.48%	↑
Prenatal and Postpartum Care—Postpartum Care	62.94%	63.23%	59.63%	59.02%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.08%	86.42%	88.40%	86.42%	↔
Use of Imaging Studies for Low Back Pain	78.42%	75.58%	77.47%	75.14%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	57.64%	77.55%	78.94%	79.86%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	65.97%	79.63%	74.54%	73.84%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	38.19%	52.78%	47.69%	53.01%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.31%	72.19%	75.69%	71.53%	↔

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

Table B.34—HEDIS 2014 Trend Table for Kaiser North—Sacramento County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	15.71%	16.07%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	53.84	57.00	48.07	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	413.25	410.03	370.32	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	93.04%	94.54%	95.24%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	92.53%	93.99%	95.09%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	54.76%	47.17%	54.55%	50.91%	↔
Cervical Cancer Screening	—	—	—	89.97%	Not Comparable
Childhood Immunization Status—Combination 3	80.24%	82.39%	83.88%	86.11%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	99.29%	98.38%	99.48%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	91.81%	90.32%	88.25%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	91.19%	91.82%	84.70%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	92.95%	92.53%	85.87%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	77.76%	81.69%	79.87%	80.00%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	67.52%	71.89%	66.16%	64.11%	↔
Comprehensive Diabetes Care—HbA1c Testing	94.00%	95.57%	94.09%	94.47%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	63.11%	61.41%	59.37%	59.92%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	62.67%	65.59%	66.79%	68.77%	↔
Comprehensive Diabetes Care—LDL-C Screening	92.06%	94.29%	92.70%	93.20%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.14%	89.44%	89.18%	93.44%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	21.54%	26.06%	27.30%	27.51%	↔
Controlling High Blood Pressure	—	—	76.40%	82.00%	↑
Immunizations for Adolescents—Combination 1	—	80.91%	88.91%	86.14%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	56.75%	70.81%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	27.16%	42.79%	↑
Prenatal and Postpartum Care—Postpartum Care	71.71%	75.00%	75.55%	71.27%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.64%	93.33%	91.61%	92.82%	↔
Use of Imaging Studies for Low Back Pain	87.46%	92.05%	89.48%	93.02%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	52.82%	73.52%	89.84%	92.61%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	60.33%	75.92%	89.41%	91.14%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	59.84%	75.56%	89.36%	91.11%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.03%	72.22%	77.88%	80.25%	↑

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

Table B.35—HEDIS 2014 Trend Table for Kaiser South—San Diego County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	17.51%	11.42%	▲
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	37.16	38.94	30.39	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	478.54	479.83	406.16	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	92.20%	93.22%	93.76%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	91.69%	92.74%	93.57%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	20.48%	38.30%	NA	NA	Not Comparable
Cervical Cancer Screening	—	—	—	87.21%	Not Comparable
Childhood Immunization Status—Combination 3	84.13%	87.02%	87.91%	88.11%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	99.48%	99.52%	99.51%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	94.39%	94.40%	93.60%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	94.52%	95.31%	89.97%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	96.49%	96.97%	88.17%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	85.78%	87.95%	85.10%	88.86%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	77.12%	75.15%	76.07%	81.71%	↑
Comprehensive Diabetes Care—HbA1c Testing	93.95%	96.23%	94.84%	96.56%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	65.52%	69.73%	69.91%	69.19%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	66.50%	69.43%	69.91%	69.19%	↔
Comprehensive Diabetes Care—LDL-C Screening	93.63%	95.18%	92.84%	94.77%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	94.61%	95.18%	93.41%	94.91%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	21.24%	18.98%	18.34%	17.88%	↔
Controlling High Blood Pressure	—	—	84.18%	86.37%	↔
Immunizations for Adolescents—Combination 1	—	88.30%	89.00%	85.54%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	61.18%	62.55%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	29.80%	32.73%	↔
Prenatal and Postpartum Care—Postpartum Care	68.47%	73.21%	70.20%	69.86%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.19%	94.74%	91.41%	91.39%	↔
Use of Imaging Studies for Low Back Pain	84.18%	76.00%	83.03%	88.00%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	98.06%	97.80%	99.49%	99.57%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	51.17%	65.11%	91.46%	87.79%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	59.75%	76.31%	94.11%	91.18%	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.58%	68.55%	70.72%	73.70%	↑

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

Table B.36—HEDIS 2014 Trend Table for Kern Family Health Care—Kern County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	8.77%	14.94%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	46.64	51.02	50.26	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	282.07	255.50	263.68	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	83.81%	87.71%	88.95%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	90.74%	93.48%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	84.24%	87.62%	89.62%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	18.27%	15.69%	23.02%	26.35%	↔
Cervical Cancer Screening	—	—	—	59.37%	Not Comparable
Childhood Immunization Status—Combination 3	74.21%	68.61%	65.45%	66.67%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.23%	92.37%	93.24%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	84.12%	82.18%	84.37%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	79.80%	79.43%	81.39%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	81.78%	82.20%	80.60%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	64.96%	72.81%	75.36%	75.67%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	32.36%	52.55%	45.80%	45.01%	↔
Comprehensive Diabetes Care—HbA1c Testing	79.81%	82.12%	80.29%	80.05%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	36.50%	45.26%	47.45%	44.53%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.20%	34.31%	33.58%	37.71%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.40%	79.38%	76.28%	77.86%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.45%	80.11%	77.55%	82.48%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	54.26%	45.99%	44.53%	46.96%	↔
Controlling High Blood Pressure	—	—	64.96%	68.37%	↔
Immunizations for Adolescents—Combination 1	—	62.53%	75.67%	78.83%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	45.85%	49.72%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	21.75%	24.01%	↔
Prenatal and Postpartum Care—Postpartum Care	61.07%	60.34%	62.04%	61.07%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	78.35%	81.27%	83.70%	81.02%	↔
Use of Imaging Studies for Low Back Pain	71.89%	76.45%	74.07%	75.41%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	62.29%	61.80%	64.23%	67.15%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	46.96%	51.58%	66.42%	66.91%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	29.44%	38.44%	48.91%	56.20%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.32%	69.10%	67.64%	66.18%	↔

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

Table B.37—HEDIS 2014 Trend Table for L.A. Care Health Plan—Los Angeles County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	17.05%	15.50%	▲
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	31.02	32.23	35.61	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	191.44	185.93	310.27	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	73.44%	73.03%	78.93%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	78.85%	78.09%	80.72%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	72.28%	72.87%	78.17%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	40.68%	32.31%	35.44%	27.88%	↓
Cervical Cancer Screening	—	—	—	64.25%	Not Comparable
Childhood Immunization Status—Combination 3	79.95%	81.45%	80.15%	77.78%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.16%	91.06%	91.83%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	86.98%	82.93%	82.82%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	88.20%	87.15%	83.89%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	86.43%	85.89%	79.45%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58.45%	64.25%	65.94%	60.05%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.72%	50.72%	49.76%	46.25%	↔
Comprehensive Diabetes Care—HbA1c Testing	85.02%	83.82%	84.30%	83.54%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.65%	42.27%	48.07%	41.65%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	37.44%	36.96%	37.68%	36.08%	↔
Comprehensive Diabetes Care—LDL-C Screening	78.99%	79.23%	79.95%	80.15%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.26%	79.47%	81.64%	84.99%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.55%	42.03%	39.37%	47.46%	▼
Controlling High Blood Pressure	—	—	61.59%	57.14%	↔
Immunizations for Adolescents—Combination 1	—	60.53%	72.15%	73.12%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	79.80%	67.42%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	57.70%	45.71%	↓
Prenatal and Postpartum Care—Postpartum Care	55.31%	61.26%	55.80%	54.24%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.13%	80.63%	85.75%	79.90%	↓
Use of Imaging Studies for Low Back Pain	80.18%	81.64%	80.14%	80.40%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	65.62%	64.65%	71.91%	71.84%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	68.28%	70.22%	74.58%	73.06%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	58.35%	57.63%	67.31%	62.62%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	80.63%	77.54%	72.46%	69.49%	↔

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

**Table B.38—HEDIS 2014 Trend Table for Molina Healthcare of California Partner Plan, Inc.—
Riverside/San Bernardino Counties**

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.65%	14.03%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	43.22	43.60	39.94	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	285.69	260.50	206.96	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	81.55%	86.05%	87.83%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	92.11%	95.56%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	81.41%	84.41%	86.60%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	21.50%	20.13%	30.23%	27.64%	↔
Cervical Cancer Screening	—	—	—	60.81%	Not Comparable
Childhood Immunization Status—Combination 3	53.04%	59.63%	63.86%	69.57%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.88%	93.65%	92.67%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	83.76%	83.03%	85.02%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	82.68%	81.96%	85.15%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	84.19%	84.51%	83.63%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58.09%	59.33%	56.52%	59.60%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	37.36%	54.83%	46.68%	50.99%	↔
Comprehensive Diabetes Care—HbA1c Testing	78.13%	78.65%	81.92%	82.56%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	34.40%	40.00%	43.48%	38.19%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.70%	34.83%	35.93%	34.00%	↔
Comprehensive Diabetes Care—LDL-C Screening	75.63%	77.30%	82.61%	79.69%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.73%	81.80%	83.30%	81.90%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	55.58%	48.76%	43.71%	48.79%	↔
Controlling High Blood Pressure	—	—	53.83%	47.22%	↓
Immunizations for Adolescents—Combination 1	—	60.88%	69.10%	73.77%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	31.87%	43.36%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	14.51%	25.22%	↑
Prenatal and Postpartum Care—Postpartum Care	50.88%	43.84%	28.99%	47.46%	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	68.58%	77.17%	64.27%	71.52%	↑
Use of Imaging Studies for Low Back Pain	76.13%	76.40%	78.21%	77.08%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	42.46%	44.32%	42.00%	55.19%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	55.22%	64.97%	59.40%	66.00%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	44.08%	57.08%	49.42%	57.40%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.50%	74.77%	68.39%	72.73%	↔

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

**Table B.39—HEDIS 2014 Trend Table for Molina Healthcare of California Partner Plan, Inc.—
Sacramento County**

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.20%	13.71%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	44.96	47.83	50.20	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	238.15	261.22	257.68	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	78.84%	73.99%	79.52%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	NA	82.86%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	74.23%	73.63%	79.48%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	27.19%	28.29%	23.08%	32.39%	↑
Cervical Cancer Screening	—	—	—	60.63%	Not Comparable
Childhood Immunization Status—Combination 3	54.31%	50.12%	54.06%	59.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.79%	94.81%	94.51%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	84.21%	84.09%	83.89%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	83.45%	83.80%	82.85%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	83.38%	84.20%	80.58%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.62%	58.22%	54.65%	52.76%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	48.83%	56.22%	47.91%	48.79%	↔
Comprehensive Diabetes Care—HbA1c Testing	79.34%	81.78%	78.60%	79.25%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.77%	46.89%	46.05%	45.25%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.15%	33.78%	31.63%	34.44%	↔
Comprehensive Diabetes Care—LDL-C Screening	69.48%	69.33%	70.00%	75.28%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.00%	83.11%	80.47%	79.47%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.78%	40.89%	43.26%	46.36%	↔
Controlling High Blood Pressure	—	—	51.29%	47.23%	↔
Immunizations for Adolescents—Combination 1	—	55.32%	66.04%	67.33%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	31.72%	51.36%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	17.24%	22.27%	↔
Prenatal and Postpartum Care—Postpartum Care	49.44%	51.36%	37.47%	43.93%	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	73.27%	81.45%	69.62%	74.39%	↔
Use of Imaging Studies for Low Back Pain	78.95%	84.03%	83.24%	81.50%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	61.95%	62.33%	54.61%	45.70%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	62.65%	64.65%	59.34%	56.51%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	55.68%	58.37%	49.65%	49.89%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.49%	76.10%	73.21%	67.31%	↔

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

**Table B.40—HEDIS 2014 Trend Table for Molina Healthcare of California Partner Plan, Inc.—
San Diego County**

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	14.45%	14.93%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	43.3	45.58	40.54	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	331.91	305.90	228.23	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	86.72%	85.15%	86.03%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	94.74%	79.66%	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	85.85%	86.01%	87.07%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	17.28%	18.21%	17.33%	28.29%	↑
Cervical Cancer Screening	—	—	—	68.11%	Not Comparable
Childhood Immunization Status—Combination 3	72.33%	73.19%	75.00%	76.89%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.76%	95.93%	95.73%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	88.46%	88.02%	88.81%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	87.55%	88.31%	89.06%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	83.75%	85.26%	86.20%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	70.40%	62.00%	62.30%	60.71%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	49.33%	56.44%	58.55%	55.63%	↔
Comprehensive Diabetes Care—HbA1c Testing	82.06%	84.44%	88.76%	87.64%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	42.60%	46.22%	57.85%	49.45%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	35.65%	42.22%	47.54%	40.18%	↓
Comprehensive Diabetes Care—LDL-C Screening	76.91%	78.22%	86.42%	82.12%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.35%	80.22%	84.31%	84.99%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	48.21%	46.67%	32.55%	41.50%	▼
Controlling High Blood Pressure	—	—	52.76%	53.88%	↔
Immunizations for Adolescents—Combination 1	—	71.30%	80.83%	81.44%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	35.33%	45.12%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	18.63%	25.18%	↑
Prenatal and Postpartum Care—Postpartum Care	63.19%	61.40%	51.52%	64.68%	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.59%	88.94%	79.72%	83.00%	↔
Use of Imaging Studies for Low Back Pain	77.66%	71.98%	72.00%	68.64%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	53.01%	57.67%	64.79%	68.30%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	58.56%	61.86%	65.96%	62.28%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	54.63%	52.33%	55.16%	53.57%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.71%	78.89%	74.74%	74.29%	↔

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

Table B.41—HEDIS 2014 Trend Table for Partnership HealthPlan of California—Marin County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	16.04%	16.45%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	48.34	43.50	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	304.46	342.84	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	76.74%	84.90%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	76.71%	87.77%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	NA	46.15%	Not Comparable
Cervical Cancer Screening	—	—	—	74.45%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	78.35%	75.35%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	98.76%	99.10%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	87.69%	90.64%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	87.25%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	84.18%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	60.71%	70.29%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	42.46%	49.64%	↔
Comprehensive Diabetes Care—HbA1c Testing	—	—	87.70%	88.77%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	50.40%	48.91%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	34.13%	40.22%	↔
Comprehensive Diabetes Care—LDL-C Screening	—	—	71.03%	76.45%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	79.37%	83.70%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	—	—	40.08%	43.84%	↔
Controlling High Blood Pressure	—	—	50.65%	64.77%	↑
Immunizations for Adolescents—Combination 1	—	—	67.47%	75.00%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	43.64%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	24.55%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	57.75%	67.63%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	78.17%	84.89%	↔
Use of Imaging Studies for Low Back Pain	—	—	85.71%	S	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	83.33%	83.70%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	63.89%	68.86%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	44.44%	60.10%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	67.59%	75.83%	↑

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

Table B.42—HEDIS 2014 Trend Table for Partnership HealthPlan of California—Mendocino County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	9.81%	11.46%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	—	57.94	56.02	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	—	331.59	308.59	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	—	84.48%	82.37%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	—	85.61%	80.80%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	28.57%	48.05%	↑
Cervical Cancer Screening	—	—	—	66.18%	Not Comparable
Childhood Immunization Status—Combination 3	—	—	61.86%	61.08%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	—	95.45%	95.80%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	—	89.15%	88.64%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	—	NA	88.51%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	—	NA	88.35%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	57.18%	63.74%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	38.86%	39.34%	↔
Comprehensive Diabetes Care—HbA1c Testing	—	—	92.82%	82.64%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	—	—	49.75%	41.32%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	—	—	37.38%	29.23%	↓
Comprehensive Diabetes Care—LDL-C Screening	—	—	76.73%	65.71%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	78.71%	75.16%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	—	—	37.38%	49.67%	▼
Controlling High Blood Pressure	—	—	57.43%	59.55%	↔
Immunizations for Adolescents—Combination 1	—	—	51.46%	57.65%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	NA	62.58%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	NA	32.52%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	—	—	69.68%	64.94%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	88.01%	83.33%	↔
Use of Imaging Studies for Low Back Pain	—	—	88.05%	85.48%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	—	—	69.91%	77.86%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	—	—	55.79%	51.58%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	—	—	31.71%	36.98%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	62.04%	63.92%	↔

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

**Table B.43—HEDIS 2014 Trend Table for Partnership HealthPlan of California—
Napa/Solano/Yolo Counties**

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.25%	15.60%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	47.82	52.33	53.57	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	256.88	312.13	311.38	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	82.13%	84.46%	89.71%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	80.88%	90.48%	94.44%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	82.38%	82.35%	89.42%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.08%	42.76%	33.18%	34.31%	↔
Cervical Cancer Screening	—	—	—	69.59%	Not Comparable
Childhood Immunization Status—Combination 3	70.14%	71.93%	68.87%	72.32%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	94.91%	96.49%	96.81%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	82.91%	86.42%	87.79%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	80.35%	83.67%	85.84%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	77.25%	84.94%	83.80%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	60.31%	69.27%	66.67%	65.21%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	54.77%	56.79%	53.42%	60.34%	↑
Comprehensive Diabetes Care—HbA1c Testing	84.04%	86.64%	85.65%	82.48%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	54.77%	60.58%	53.64%	52.31%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	49.89%	49.22%	42.16%	46.96%	↔
Comprehensive Diabetes Care—LDL-C Screening	79.38%	78.17%	77.70%	77.86%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.49%	83.74%	84.33%	86.86%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	34.59%	28.73%	35.76%	37.47%	↔
Controlling High Blood Pressure	—	—	53.86%	56.72%	↔
Immunizations for Adolescents—Combination 1	—	56.81%	65.33%	64.10%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	59.90%	61.68%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	39.41%	40.23%	↔
Prenatal and Postpartum Care—Postpartum Care	69.51%	70.29%	75.92%	68.85%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.02%	87.27%	81.41%	80.00%	↔
Use of Imaging Studies for Low Back Pain	88.42%	88.52%	88.95%	89.17%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	57.41%	74.77%	77.44%	69.76%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	49.77%	65.05%	67.91%	65.12%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	42.13%	53.70%	52.79%	54.15%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.54%	74.34%	74.26%	73.83%	↔

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

Table B.44—HEDIS 2014 Trend Table for Partnership HealthPlan of California—Sonoma County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.05%	12.79%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	43.17	44.10	39.40	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	283.01	345.59	354.14	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	71.41%	69.27%	84.41%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	88.57%	85.29%	88.89%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	73.94%	72.08%	85.05%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	20.97%	47.47%	27.33%	36.96%	↔
Cervical Cancer Screening	—	—	—	72.02%	Not Comparable
Childhood Immunization Status—Combination 3	71.00%	76.62%	74.01%	79.13%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	95.24%	96.25%	98.23%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	86.47%	88.58%	90.32%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	83.26%	85.70%	87.25%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	84.36%	88.23%	86.73%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.22%	76.12%	69.98%	70.56%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	49.56%	54.24%	57.62%	60.10%	↔
Comprehensive Diabetes Care—HbA1c Testing	87.33%	90.18%	92.27%	89.05%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	51.78%	59.38%	51.66%	52.55%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.44%	43.75%	39.74%	41.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	68.89%	74.33%	76.60%	79.81%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.33%	80.13%	80.13%	82.24%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	37.11%	27.01%	34.88%	34.55%	↔
Controlling High Blood Pressure	—	—	54.53%	60.69%	↔
Immunizations for Adolescents—Combination 1	—	53.01%	65.66%	74.93%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	63.71%	61.42%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	41.62%	44.29%	↔
Prenatal and Postpartum Care—Postpartum Care	67.06%	75.69%	73.73%	74.14%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.15%	82.96%	85.97%	89.10%	↔
Use of Imaging Studies for Low Back Pain	90.15%	90.42%	90.32%	90.56%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	77.31%	86.31%	87.15%	85.12%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	54.40%	69.37%	68.46%	65.12%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	47.69%	54.99%	51.64%	56.83%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.69%	72.16%	74.43%	81.31%	↑

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

Table B.45—HEDIS 2014 Trend Table for San Francisco Health Plan—San Francisco County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	15.81%	13.86%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	26.68	35.34	33.03	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	354.39	348.95	383.10	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	73.20%	76.81%	87.32%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	NA	81.82%	95.92%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	71.43%	78.74%	86.31%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	44.53%	45.45%	53.75%	44.01%	↓
Cervical Cancer Screening	—	—	—	74.47%	Not Comparable
Childhood Immunization Status—Combination 3	87.27%	87.04%	85.81%	85.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	92.98%	95.95%	97.01%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	87.90%	89.57%	92.55%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	90.08%	93.16%	94.70%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	86.78%	91.13%	91.04%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	73.71%	78.64%	74.77%	76.57%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	70.10%	69.72%	67.59%	62.41%	↔
Comprehensive Diabetes Care—HbA1c Testing	90.38%	91.08%	90.97%	89.33%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	64.09%	63.38%	62.27%	63.57%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	47.94%	48.83%	47.69%	47.80%	↔
Comprehensive Diabetes Care—LDL-C Screening	83.16%	83.33%	80.56%	79.35%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.05%	83.57%	87.73%	86.77%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	26.29%	26.53%	26.39%	24.36%	↔
Controlling High Blood Pressure	—	—	66.46%	63.42%	↔
Immunizations for Adolescents—Combination 1	—	64.35%	81.02%	81.71%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	42.82%	52.10%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	21.55%	32.87%	↑
Prenatal and Postpartum Care—Postpartum Care	63.57%	75.64%	71.76%	70.40%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.26%	93.44%	87.96%	93.24%	↑
Use of Imaging Studies for Low Back Pain	82.23%	82.98%	86.53%	84.86%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	60.65%	76.16%	85.19%	86.81%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	78.47%	80.56%	85.19%	82.41%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	70.37%	72.69%	83.80%	79.17%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	85.19%	84.95%	84.26%	86.81%	↔

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

Table B.46—HEDIS 2014 Trend Table for Santa Clara Family Health Plan—Santa Clara County

Measure	2011	2012	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	—	—	13.77%	15.20%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	—	35.89	34.79	32.64	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	—	292.77	267.45	260.02	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	—	86.05%	87.60%	87.39%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	—	87.18%	88.10%	89.01%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	—	84.85%	88.08%	87.91%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	31.41%	25.81%	26.43%	29.40%	↔
Cervical Cancer Screening	—	—	—	67.40%	Not Comparable
Childhood Immunization Status—Combination 3	79.40%	80.05%	73.72%	75.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	—	96.22%	96.87%	97.15%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	—	88.63%	88.90%	88.94%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	—	89.69%	88.92%	90.46%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	—	86.78%	87.81%	87.46%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.70%	45.01%	53.53%	56.69%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	51.52%	47.69%	41.85%	46.72%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.38%	86.62%	86.62%	86.86%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.41%	51.09%	55.47%	54.01%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	51.28%	37.96%	42.82%	41.36%	↔
Comprehensive Diabetes Care—LDL-C Screening	78.32%	81.02%	79.08%	81.02%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.22%	80.05%	79.81%	83.45%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	34.73%	40.88%	34.79%	33.82%	↔
Controlling High Blood Pressure	—	—	52.80%	52.55%	↔
Immunizations for Adolescents—Combination 1	—	69.34%	75.67%	75.43%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	—	—	58.61%	61.13%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	—	—	35.95%	41.98%	↑
Prenatal and Postpartum Care—Postpartum Care	62.73%	58.39%	67.40%	59.61%	↓
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.56%	82.73%	82.97%	86.13%	↔
Use of Imaging Studies for Low Back Pain	82.30%	80.37%	82.42%	86.37%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	60.88%	64.23%	66.91%	71.53%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	61.81%	63.99%	67.88%	67.40%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	40.05%	45.74%	41.85%	49.15%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.61%	75.67%	72.75%	69.59%	↔

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

Tables C.1 through C.46 provide two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

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

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the “2013–14 Rate Difference” column in Tables C.1 through C.46. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 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.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

Table C.1—Alameda Alliance for Health—Alameda HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	15.86%	19.54%	▼
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	69.61	53.35	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	481.81	387.05	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.99%	84.69%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	94.30%	92.80%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.07%	85.18%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months	85.71%	100.0%	↑
Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years	85.99%	86.01%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years	86.15%	87.57%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years	80.59%	79.65%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.29%	56.93%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.07%	43.55%	↓
Comprehensive Diabetes Care—HbA1c Testing	84.43%	84.43%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	53.53%	54.74%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	38.20%	30.90%	↓
Comprehensive Diabetes Care—LDL-C Screening	78.10%	78.10%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.21%	85.16%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	34.55%	45.26%	▼

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

Table C.2—Anthem Blue Cross Partnership Plan—Alameda HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	15.98%	19.74%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	114.02	115.98	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	189.35	294.17	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	79.85%	83.77%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	75.70%	82.80%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	63.92%	78.70%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	84.46%	79.11%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	77.30%	70.43%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	35.04%	38.72%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	32.12%	34.96%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	65.45%	77.88%	↑
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	31.14%	27.88%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	19.71%	19.91%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	55.72%	66.81%	↑
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	76.40%	78.32%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	63.26%	66.15%	↔

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

Table C.3—Anthem Blue Cross Partnership Plan—Contra Costa HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	23.00%	19.78%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	93.77	97.01	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	201.70	284.86	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.49%	81.38%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.72%	78.77%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	89.33%	89.36%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	77.78%	87.61%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	82.10%	83.50%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	56.67%	44.57%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	36.67%	36.00%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	75.00%	76.57%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	43.33%	33.71%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	34.17%	33.71%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	67.50%	69.71%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	76.67%	84.00%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	47.50%	58.29%	↔

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

Table C.4—Anthem Blue Cross Partnership Plan—Fresno HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	16.79%	16.18%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	69.24	74.31	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	401.81	367.46	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.19%	83.57%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.44%	85.08%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	80.80%	84.85%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	81.52%	84.70%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	75.98%	79.00%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	56.20%	50.88%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	37.71%	39.82%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	82.24%	78.98%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	43.31%	33.63%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	35.52%	28.54%	↓
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	75.67%	74.56%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	84.91%	80.75%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	46.47%	51.55%	↔

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

Table C.5—Anthem Blue Cross Partnership Plan—Kings HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	19.82%	S	▲
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	140.74	119.47	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	662.36	563.40	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.55%	82.43%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.28%	83.70%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	80.00%	80.00%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	NA	95.92%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	NA	84.93%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	57.14%	48.60%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	34.69%	42.46%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	74.15%	72.63%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	39.46%	27.93%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	25.85%	24.02%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	73.47%	69.27%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	78.23%	80.45%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	55.10%	64.80%	↔

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

Table C.6—Anthem Blue Cross Partnership Plan—Madera HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	17.31%	S	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	95.08	98.73	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	542.71	509.81	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	78.72%	86.18%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.04%	84.62%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	90.48%	93.62%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	NA	97.44%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	NA	92.86%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	64.29%	62.84%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	59.18%	53.38%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	91.84%	84.46%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	55.10%	42.57%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	33.67%	34.46%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	76.53%	70.27%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	85.71%	82.43%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	34.69%	50.00%	▼

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

Table C.7—Anthem Blue Cross Partnership Plan—Sacramento HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	15.52%	13.26%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	85.17	82.77	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	331.70	356.44	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	67.13%	82.21%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	85.29%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	70.32%	83.72%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	88.37%	92.31%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	77.94%	78.10%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	83.54%	83.31%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	81.66%	79.13%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	57.18%	45.58%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	31.14%	38.94%	↑
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	81.02%	75.66%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	53.04%	41.59%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	34.06%	30.09%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	71.53%	67.70%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.54%	84.96%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	39.90%	47.12%	▼

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

Table C.8—Anthem Blue Cross Partnership Plan—San Francisco HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	15.35%	17.38%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	89.99	95.72	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	349.50	373.20	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.49%	84.77%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	82.14%	84.60%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	NA	70.97%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	94.12%	77.50%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	87.78%	88.35%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	62.97%	55.33%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	47.52%	48.67%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	87.17%	82.89%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	55.10%	44.67%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	41.11%	30.89%	↓
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	76.68%	70.44%	↓
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	86.88%	84.00%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	34.40%	47.56%	▼

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

Table C.9—Anthem Blue Cross Partnership Plan—Santa Clara HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	14.47%	16.33%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	62.01	74.19	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	364.03	374.95	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.02%	89.63%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.38%	88.49%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	87.16%	81.45%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	88.81%	86.89%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	87.01%	83.11%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	54.26%	40.84%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	50.61%	43.93%	↓
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	81.51%	84.33%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	49.39%	44.59%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	41.61%	37.09%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	79.32%	79.91%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	86.37%	82.78%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	41.36%	46.58%	↔

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

Table C.10—Anthem Blue Cross Partnership Plan—Tulare HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	15.70%	12.83%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	85.58	83.89	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	494.61	561.54	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.10%	85.94%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.27%	87.12%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	83.87%	89.09%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	81.43%	86.57%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	83.68%	86.76%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	63.02%	51.11%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	36.01%	42.70%	↑
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	80.78%	83.19%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	46.96%	39.82%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	35.77%	29.42%	↓
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	74.70%	71.46%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	84.18%	84.96%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	42.09%	47.79%	↔

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

Table C.11—CalOptima—Orange HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	18.82%	16.83%	▲
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	46.80	51.03	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	559.23	573.24	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.78%	91.90%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	93.77%	90.06%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.88%	91.16%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	85.60%	85.27%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	86.36%	85.47%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	85.40%	85.84%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	81.99%	80.71%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	70.23%	50.46%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	70.47%	63.89%	↓
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	85.58%	86.34%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	65.58%	57.64%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	46.74%	46.53%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	84.42%	86.81%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	85.81%	87.73%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	29.53%	33.33%	↔

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

Table C.12—CalViva Health—Fresno HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	12.30%	15.39%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	66.02	70.05	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	551.16	555.25	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.76%	85.27%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	89.61%	82.26%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.44%	86.97%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	91.46%	100.0%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	90.62%	91.65%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	93.76%	93.33%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	90.79%	88.51%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	49.39%	55.47%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	50.12%	54.01%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	86.62%	81.75%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.50%	39.17%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	38.20%	34.79%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	82.00%	74.45%	↓
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	81.27%	81.27%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	42.09%	54.50%	▼

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

Table C.13—CalViva Health—Kings HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	12.69%	8.57%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	115.90	113.80	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	737.46	651.69	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.71%	91.32%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.11%	92.14%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	89.47%	87.65%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	NA	90.00%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	NA	85.71%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	49.53%	46.98%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	41.59%	52.68%	↑
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	49.07%	80.87%	↑
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	37.85%	39.26%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	28.50%	34.56%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	49.07%	76.51%	↑
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.24%	80.20%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	34.11%	50.34%	▼

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

Table C.14—CalViva Health—Madera HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	14.04%	16.36%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	72.47	78.44	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	648.89	665.45	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.11%	85.77%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.55%	89.71%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	90.79%	97.17%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	NA	94.29%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	NA	88.42%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	51.85%	57.53%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	59.26%	55.52%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	89.35%	89.63%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	48.61%	43.81%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	32.87%	36.12%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	74.54%	74.58%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	84.26%	87.63%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	43.98%	49.16%	↔

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

Table C.15—Care1st Partner Plan—San Diego HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	17.35%	16.90%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	73.34	68.85	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	415.00	399.63	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	81.13%	85.13%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.24%	85.98%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	70.83%	69.03%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	82.50%	62.64%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	78.13%	70.67%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	57.00%	41.61%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	38.40%	36.98%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	82.80%	81.02%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.20%	44.04%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	38.60%	35.04%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	79.40%	72.51%	↓
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	88.40%	81.27%	↓
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	48.00%	64.72%	▼

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

Table C.16—CenCal Health—San Luis Obispo HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	16.54%	14.96%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	100.09	95.46	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	599.51	598.85	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.88%	83.97%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.25%	90.28%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	73.87%	76.07%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	83.22%	83.22%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	76.61%	79.72%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	72.67%	68.56%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	57.27%	61.47%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	83.14%	83.85%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	60.47%	61.76%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	45.35%	45.04%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	81.69%	80.74%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	88.08%	88.39%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	34.01%	27.76%	↔

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

Table C.17—CenCal Health—Santa Barbara HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	13.88%	16.41%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	101.65	102.10	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	566.20	596.56	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.86%	89.25%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	87.10%	83.33%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.10%	89.19%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	86.40%	90.99%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	87.97%	90.32%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	89.83%	89.52%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	68.61%	67.64%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	68.37%	66.18%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	84.91%	87.10%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	61.07%	63.50%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	42.09%	45.01%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	81.27%	79.32%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	85.89%	86.13%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	31.39%	26.76%	↔

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

Table C.18—Central California Alliance for Health—Merced HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	14.40%	15.78%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	75.54	76.83	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	536.12	539.90	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.83%	90.10%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.28%	91.17%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	90.32%	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	91.17%	91.03%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	90.89%	94.07%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	88.74%	86.86%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	61.80%	43.31%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	53.28%	51.82%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	84.67%	88.32%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	48.66%	39.42%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	33.33%	28.47%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	79.32%	81.02%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	86.13%	86.86%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	43.80%	52.07%	▼

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

**Table C.19—Central California Alliance for Health—Monterey/Santa Cruz
HEDIS 2014 SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	14.47%	13.89%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	79.25	74.76	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	543.55	549.69	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.32%	89.63%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	89.13%	87.80%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.86%	90.06%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	96.67%	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	92.76%	95.29%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	91.46%	92.34%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	88.47%	87.52%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	65.21%	59.85%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	63.99%	62.04%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	86.37%	88.08%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	51.58%	51.82%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	40.88%	37.96%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	76.16%	81.75%	↑
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	81.02%	82.97%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	36.98%	40.88%	↔

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

Table C.20—Community Health Group Partnership Plan—San Diego HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	17.03%	14.88%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	62.49	46.05	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	495.48	384.72	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.05%	89.03%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	90.24%	95.31%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.76%	90.33%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	97.37%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	88.46%	88.30%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	94.09%	89.97%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	87.12%	84.81%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	62.53%	44.04%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	60.58%	57.18%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	90.27%	86.86%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	58.88%	46.47%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	46.47%	42.58%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	86.62%	82.97%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	88.08%	84.91%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	30.66%	39.66%	▼

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

Table C.21—Contra Costa Health Plan—Contra Costa HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	19.48%	14.13%	▲
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	83.56	74.83	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	299.06	342.49	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.68%	87.41%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	86.54%	95.00%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.83%	85.24%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	74.13%	87.47%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	82.34%	86.49%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	79.63%	82.72%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	56.20%	62.77%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	54.50%	52.55%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	88.56%	84.43%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	55.96%	54.01%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	43.55%	42.58%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	84.43%	75.91%	↓
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	86.13%	83.21%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	33.82%	36.98%	↔

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

Table C.22—Gold Coast Health Plan—Ventura HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	23.16%	15.06%	▲
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	70.16	64.02	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	493.66	361.16	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.46%	89.11%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	88.37%	92.50%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.97%	90.10%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	75.00%	89.74%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	61.92%	83.61%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	NA	77.69%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	NA	72.72%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	57.66%	59.85%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	44.53%	44.04%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	85.16%	85.16%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	35.04%	49.88%	↑
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	36.25%	34.79%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	79.08%	80.05%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	86.13%	81.51%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	58.64%	42.34%	▲

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

Table C.23—Health Net Community Solutions, Inc.—Kern HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	11.72%	12.18%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	80.74	83.64	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	219.48	302.99	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	78.34%	80.38%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.90%	81.49%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	68.83%	73.87%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	72.27%	70.16%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	73.89%	63.26%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	48.66%	48.66%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	43.55%	46.72%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	73.24%	79.32%	↑
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	40.15%	39.17%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	40.88%	40.63%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	75.91%	77.62%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	83.21%	82.48%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	49.15%	54.50%	↔

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

Table C.24—Health Net Community Solutions, Inc.—Los Angeles HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	14.16%	13.40%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	55.77	52.60	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	267.73	262.13	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	77.01%	81.62%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	86.48%	87.45%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.39%	82.59%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	86.07%	73.01%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	76.93%	78.05%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	83.57%	81.11%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	78.40%	73.04%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	50.36%	53.04%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	43.55%	48.42%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	78.83%	79.56%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.50%	45.01%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	38.20%	39.17%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	78.10%	78.83%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	84.43%	83.45%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	44.28%	45.50%	↔

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

Table C.25—Health Net Community Solutions, Inc.—Sacramento HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	14.03%	13.70%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	65.06	64.11	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	399.51	358.78	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	69.20%	74.02%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	83.93%	84.75%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	71.03%	72.64%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	97.22%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	78.66%	79.88%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	86.48%	83.38%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	81.16%	73.71%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	48.91%	47.20%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	37.71%	41.12%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	80.78%	78.10%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	49.64%	48.91%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	37.96%	35.28%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	71.78%	71.29%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	85.64%	82.00%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	39.42%	43.80%	↔

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

Table C.26—Health Net Community Solutions, Inc.—San Diego HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	17.88%	17.37%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	71.22	69.30	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	406.58	319.25	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.17%	90.18%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.79%	90.62%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	81.31%	75.61%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	85.96%	81.54%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	80.42%	77.03%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	53.28%	46.47%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	43.31%	38.93%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	86.37%	76.16%	↓
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	51.82%	40.15%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	43.80%	33.09%	↓
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	81.75%	70.07%	↓
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	87.59%	80.29%	↓
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	37.71%	53.28%	▼

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

Table C.27—Health Net Community Solutions, Inc.—San Joaquin HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	—	25.00%	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	104.16	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	344.91	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	75.47%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	—	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	—	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	—	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	—	NA	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	—	33.33%	Not Comparable
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	—	43.33%	Not Comparable
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	—	86.67%	Not Comparable
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	—	38.33%	Not Comparable
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	—	40.00%	Not Comparable
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	—	60.00%	Not Comparable
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	—	86.67%	Not Comparable
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	—	55.00%	Not Comparable

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

Table C.28—Health Net Community Solutions, Inc.—Stanislaus HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	10.12%	13.24%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	82.73	93.41	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	491.16	470.09	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.26%	84.15%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.47%	86.17%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	86.27%	86.32%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	90.98%	87.57%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	94.25%	83.08%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	60.58%	55.72%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	41.12%	40.39%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	89.78%	87.10%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	60.10%	54.01%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	42.82%	42.34%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	81.27%	77.86%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.97%	81.75%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	30.17%	36.50%	↔

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

Table C.29—Health Net Community Solutions, Inc.—Tulare HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	15.86%	12.77%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	71.55	70.74	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	602.84	651.79	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.74%	84.40%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	90.00%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.50%	85.63%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	94.74%	90.20%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	94.50%	94.23%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	92.00%	90.40%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	49.39%	55.96%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	45.01%	50.85%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	87.59%	80.29%	↓
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	53.77%	48.42%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	38.20%	33.82%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	76.64%	70.80%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.73%	84.18%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	38.93%	44.77%	↔

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

Table C.30—Health Plan of San Joaquin—San Joaquin HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	13.75%	13.65%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	72.22	71.99	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	474.21	438.00	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.44%	85.07%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	90.91%	93.18%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	86.39%	86.24%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	96.30%	100.0%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	89.90%	86.09%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	88.53%	87.37%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	87.69%	85.91%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	63.26%	69.10%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	45.01%	42.34%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	82.00%	81.75%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	51.09%	56.45%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	34.79%	46.72%	↑
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	77.86%	78.10%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.24%	84.18%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	43.55%	36.25%	▲

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

Table C.31—Health Plan of San Joaquin—Stanislaus HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	—	15.88%	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	105.58	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	585.69	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	87.72%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	89.27%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	—	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	—	93.20%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	—	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	—	NA	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	—	66.42%	Not Comparable
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	—	39.17%	Not Comparable
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	—	88.56%	Not Comparable
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	—	59.37%	Not Comparable
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	—	43.55%	Not Comparable
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	—	81.75%	Not Comparable
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	—	83.70%	Not Comparable
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	—	31.14%	Not Comparable

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

Table C.32—Health Plan of San Mateo—San Mateo HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	13.28%	16.78%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	58.21	60.39	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	924.90	797.31	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.95%	91.58%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	94.79%	94.84%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.23%	92.65%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	79.41%	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	74.72%	77.57%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	72.19%	72.88%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	65.03%	68.15%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	48.18%	46.72%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	57.42%	63.99%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	83.94%	88.81%	↑
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	55.72%	56.93%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	48.18%	47.20%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	83.21%	84.91%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	85.16%	90.75%	↑
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	46.72%	36.01%	▲

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

Table C.33—Inland Empire Health Plan—Riverside/San Bernardino HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	16.95%	17.37%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	75.75	82.89	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	630.72	632.06	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.22%	88.35%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	91.32%	91.64%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.78%	87.55%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	96.12%	94.61%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	86.54%	85.58%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	87.66%	86.46%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	86.60%	82.45%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	67.12%	60.18%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	60.59%	56.11%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	86.49%	87.33%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	57.43%	50.68%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	48.65%	43.21%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	86.49%	85.29%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	86.71%	89.37%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	31.31%	33.71%	↔

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

Table C.34—Kaiser North—Sacramento HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	17.05%	17.24%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	86.57	84.30	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	671.49	699.94	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	96.27%	96.00%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	95.25%	96.55%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	95.58%	93.75%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	95.56%	96.33%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	94.80%	93.19%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	80.69%	80.20%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	70.60%	66.44%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	96.19%	95.64%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	66.30%	65.66%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	73.68%	74.50%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	95.20%	94.41%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	92.87%	95.08%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	20.05%	23.15%	↔

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

Table C.35—Kaiser South—San Diego HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	20.74%	11.41%	▲
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	52.40	59.41	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	737.64	890.21	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	94.76%	96.68%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	94.24%	96.13%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	98.70%	98.80%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	97.80%	99.08%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	93.57%	96.32%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	84.15%	88.84%	↑
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	78.37%	82.96%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	94.86%	96.75%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	73.02%	72.62%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	74.52%	74.44%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	93.79%	95.74%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	94.65%	95.94%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	15.85%	16.23%	↔

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

Table C.36—Kern Family Health Care—Kern HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	17.07%	18.74%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	95.53	99.42	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	487.16	492.89	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	92.05%	90.14%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	93.33%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.17%	91.41%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	87.76%	92.59%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	86.32%	84.46%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	85.00%	79.50%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	85.37%	78.43%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	73.72%	72.75%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	48.18%	44.77%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	83.21%	80.78%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	56.57%	49.39%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	40.69%	40.15%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	83.76%	80.78%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	84.85%	83.21%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	36.31%	38.20%	↔

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

Table C.37—L.A. Care Health Plan—Los Angeles HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	19.69%	18.44%	▲
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	61.70	57.87	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	284.56	421.46	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	73.17%	79.22%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	78.75%	79.65%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	73.59%	78.52%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	77.40%	79.34%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	81.54%	81.02%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	87.85%	83.01%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	84.37%	77.77%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	54.01%	45.50%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	47.69%	45.50%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	81.51%	84.67%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	43.80%	50.12%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	36.98%	39.42%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	78.83%	82.97%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.97%	88.56%	↑
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	45.26%	42.34%	↔

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

**Table C.38—Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino
HEDIS 2014 SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	18.15%	16.27%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	67.24	72.83	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	346.49	312.01	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	87.80%	89.83%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	90.63%	95.00%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	87.06%	89.26%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	79.18%	78.45%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	84.52%	83.40%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	83.44%	76.02%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	56.25%	49.34%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	46.88%	45.13%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	80.21%	78.76%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	47.40%	40.71%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	42.19%	35.62%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	76.56%	78.32%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	88.02%	82.96%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	44.79%	48.23%	↔

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

**Table C.39—Molina Healthcare of California Partner Plan, Inc.—Sacramento
HEDIS 2014 SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	14.68%	15.39%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	65.28	68.46	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	415.90	423.73	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	74.59%	80.05%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	83.87%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	74.40%	80.25%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	79.27%	80.95%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	87.88%	79.07%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	79.40%	74.85%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	55.80%	51.66%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	47.83%	50.33%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	73.91%	76.82%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	52.17%	45.92%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	34.06%	33.11%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	63.77%	73.73%	↑
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	81.88%	81.90%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	44.20%	44.59%	↔

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

**Table C.40—Molina Healthcare of California Partner Plan, Inc.—San Diego
HEDIS 2014 SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	17.65%	17.07%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	61.02	71.93	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	512.86	434.68	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.79%	87.49%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	94.12%	80.36%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.10%	88.57%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	80.65%	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	84.13%	86.83%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	89.63%	84.92%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	84.01%	81.87%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	58.45%	53.86%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	52.11%	56.73%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	85.21%	88.08%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	57.75%	52.54%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	51.41%	43.05%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	83.80%	83.00%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	90.14%	88.30%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	37.32%	39.51%	↔

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

Table C.41—Partnership HealthPlan of California—Marin HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	18.83%	17.72%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	62.43	61.72	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	441.02	538.03	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	79.13%	85.42%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	79.43%	88.65%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	77.97%	83.93%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	NA	84.15%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	NA	68.29%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	59.77%	68.39%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	43.10%	49.74%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	89.08%	90.67%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	55.17%	50.78%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	35.63%	44.56%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	73.56%	77.72%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	83.33%	86.53%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	35.63%	43.01%	↔

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

Table C.42—Partnership HealthPlan of California—Mendocino HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	10.68%	13.24%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	94.82	95.80	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	589.67	586.07	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.52%	83.17%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.14%	81.52%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	NA	92.98%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	NA	87.01%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	NA	85.82%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	54.51%	64.73%	↑
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	43.44%	45.35%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	90.98%	83.33%	↓
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	52.87%	45.74%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	40.57%	33.33%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	77.87%	68.22%	↓
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	83.61%	81.01%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	35.66%	45.74%	▼

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

Table C.43—Partnership HealthPlan of California—Napa/Solano/Yolo HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	15.67%	16.98%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	79.44	81.68	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	503.87	565.93	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.70%	90.49%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	91.07%	94.90%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.26%	90.39%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	86.79%	92.31%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	82.56%	85.68%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	84.64%	85.27%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	81.91%	81.25%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	61.95%	61.07%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	53.54%	62.04%	↑
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	85.62%	83.45%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	54.65%	54.50%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	43.81%	48.91%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	77.88%	78.10%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	88.72%	89.54%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	33.19%	35.28%	↔

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

Table C.44—Partnership HealthPlan of California—Sonoma HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	15.38%	14.00%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	74.66	72.33	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	577.11	597.96	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	69.54%	85.94%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	84.38%	87.88%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	75.51%	86.11%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	94.74%	91.75%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	84.06%	89.15%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	88.04%	87.34%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	67.77%	66.42%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	59.60%	59.37%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	93.38%	87.59%	↓
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	56.07%	54.01%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	46.58%	41.61%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	77.04%	78.10%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	84.33%	83.45%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	30.91%	36.25%	↔

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

Table C.45—San Francisco Health Plan—San Francisco HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	18.08%	17.88%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	74.89	75.73	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	527.95	615.01	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	77.85%	87.62%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	80.56%	95.12%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	79.97%	86.98%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	NA	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	83.67%	83.33%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	90.85%	89.41%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	87.06%	86.96%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	73.38%	69.91%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	63.43%	62.27%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	90.51%	88.43%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	65.97%	65.05%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	50.69%	47.92%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	81.48%	78.24%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	87.27%	85.42%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	24.54%	23.84%	↔

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

Table C.46—Santa Clara Family Health Plan—Santa Clara HEDIS 2014 SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	16.54%	18.25%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	42.92	45.66	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	403.89	411.17	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	88.79%	89.10%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	89.33%	88.61%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.07%	90.26%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	96.30%	80.95%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	88.74%	88.93%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	89.16%	88.55%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	89.55%	86.53%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	53.53%	51.09%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	40.15%	44.53%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	89.05%	86.86%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	61.07%	56.45%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	47.93%	49.15%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	84.67%	80.29%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	87.83%	87.35%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	29.20%	34.06%	↔

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

Tables D.1 through D.46 provide two-year trending information for the Non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

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

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the “2013–14 Rate Difference” column in Tables D.1 through D.46. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲ ▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not Comparable = A 2013–14 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.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard.

Table D.1—Alameda Alliance for Health—Alameda HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	10.47%	13.64%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	40.42	24.72	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	240.90	212.26	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	77.54%	80.91%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	73.16%	81.90%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	92.41%	94.25%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	83.84%	85.07%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	85.00%	87.03%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	84.99%	83.59%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	59.37%	61.63%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	48.91%	44.06%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	83.45%	77.48%	↓
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	51.58%	44.80%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	36.74%	28.47%	↓
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	77.62%	63.86%	↓
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.97%	73.76%	↓
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	37.47%	55.20%	▼

*Member months are a member’s “contribution” to the total yearly membership.

Table D.2—Anthem Blue Cross Partnership Plan—Alameda HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	9.84%	10.91%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	55.23	53.18	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	144.94	187.84	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	66.07%	71.79%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	62.94%	70.77%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	84.31%	85.30%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	67.90%	77.79%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	78.76%	78.54%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	77.69%	75.79%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	39.62%	46.33%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	33.46%	36.68%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	63.08%	73.36%	↑
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	27.31%	27.41%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	16.92%	15.06%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	50.38%	55.60%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	62.69%	66.02%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	65.77%	66.41%	↔

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

Table D.3—Anthem Blue Cross Partnership Plan—Contra Costa HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	8.89%	S	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	56.21	56.15	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	202.82	225.26	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	72.41%	76.47%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	58.00%	67.35%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months	96.88%	95.23%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years	84.85%	86.31%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years	85.69%	88.35%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years	82.84%	85.16%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	42.68%	48.96%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.46%	40.63%	↔
Comprehensive Diabetes Care—HbA1c Testing	60.98%	72.92%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	34.15%	40.63%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	21.95%	21.88%	↔
Comprehensive Diabetes Care—LDL-C Screening	59.76%	62.50%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	53.66%	68.75%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	60.98%	54.17%	↔

*Member months are a member’s “contribution” to the total yearly membership.

Table D.4—Anthem Blue Cross Partnership Plan—Fresno HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	10.55%	10.68%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	40.31	45.59	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	231.05	219.48	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	79.15%	81.76%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.81%	78.59%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	94.28%	93.86%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	82.89%	83.33%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	80.30%	83.46%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	76.57%	79.14%	↑
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	59.61%	54.57%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	40.63%	42.09%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	71.53%	79.29%	↑
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	38.69%	33.85%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	29.20%	29.84%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	66.42%	73.27%	↑
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	73.24%	75.95%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	54.74%	54.12%	↔

*Member months are a member’s “contribution” to the total yearly membership.

Table D.5—Anthem Blue Cross Partnership Plan—Kings HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	11.84%	S	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	61.10	61.93	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	337.12	291.39	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.82%	80.56%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.13%	68.66%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months	95.01%	94.71%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years	86.69%	83.36%	↓
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years	NA	84.26%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years	NA	84.62%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.63%	60.74%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.61%	38.04%	↔
Comprehensive Diabetes Care—HbA1c Testing	75.78%	72.39%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	37.89%	23.31%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	26.09%	14.72%	↓
Comprehensive Diabetes Care—LDL-C Screening	72.67%	67.48%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.94%	73.62%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	55.28%	65.03%	↔

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

Table D.6—Anthem Blue Cross Partnership Plan—Madera HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	2.50%	S	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	56.55	54.40	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	293.16	272.13	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	74.47%	81.82%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	65.79%	68.42%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	98.05%	98.45%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	88.48%	90.87%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	NA	90.58%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	NA	88.52%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	68.70%	59.06%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	51.91%	56.69%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	79.39%	84.25%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	49.62%	44.09%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	29.77%	22.83%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	70.23%	67.72%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	74.05%	78.74%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	37.40%	44.88%	↔

*Member months are a member’s “contribution” to the total yearly membership.

Table D.7—Anthem Blue Cross Partnership Plan—Sacramento HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	7.85%	8.70%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	47.88	48.19	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	190.39	191.26	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	60.90%	75.38%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	59.22%	70.27%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	93.23%	94.06%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	80.26%	81.70%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	81.02%	80.76%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	80.47%	78.05%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	55.96%	57.74%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	29.20%	32.30%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	67.40%	70.80%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	37.71%	35.84%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	22.63%	25.22%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	58.15%	61.50%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	61.07%	67.70%	↑
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	53.53%	52.88%	↔

*Member months are a member’s “contribution” to the total yearly membership.

**Table D.8—Anthem Blue Cross Partnership Plan—San Francisco
HEDIS 2014 Non-SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	6.56%	S	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	32.91	35.87	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	237.72	245.67	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	77.78%	82.42%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.13%	80.39%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	96.08%	96.95%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	87.28%	89.53%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	90.74%	89.73%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	89.69%	88.40%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	60.19%	66.04%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	39.81%	53.77%	↑
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	84.47%	83.02%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	48.54%	40.57%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	31.07%	25.47%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	73.79%	70.75%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.52%	75.47%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	37.86%	47.17%	↔

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

Table D.9—Anthem Blue Cross Partnership Plan—Santa Clara HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	12.43%	6.88%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	37.66	41.56	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	234.32	232.83	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.37%	83.51%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.21%	79.27%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	96.07%	95.97%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	87.40%	87.66%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	88.02%	89.89%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	87.64%	85.77%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	66.42%	51.55%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	51.82%	46.90%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	83.21%	83.19%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	52.31%	44.25%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	39.90%	39.16%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	79.32%	78.54%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	79.81%	79.87%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	38.93%	42.04%	↔

*Member months are a member’s “contribution” to the total yearly membership.

Table D.10—Anthem Blue Cross Partnership Plan—Tulare HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	7.83%	8.22%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	38.85	39.20	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	278.32	305.19	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	75.69%	84.20%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	77.22%	81.50%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	92.49%	97.77%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	82.70%	90.38%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	79.53%	88.28%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	82.13%	87.56%	↑
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	67.88%	59.20%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	35.52%	41.46%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	79.08%	81.82%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	46.47%	39.02%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	33.33%	30.60%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	70.80%	74.06%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	79.56%	77.61%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	44.28%	48.12%	↔

*Member months are a member’s “contribution” to the total yearly membership.

Table D.11—CalOptima—Orange HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	11.35%	10.83%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	34.15	32.50	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	288.81	226.81	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.58%	86.11%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	91.18%	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.39%	83.73%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months	97.45%	97.54%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years	91.29%	91.62%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years	92.03%	92.64%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years	90.99%	89.52%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	75.12%	74.77%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	62.09%	65.65%	↔
Comprehensive Diabetes Care—HbA1c Testing	81.86%	83.88%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.60%	48.83%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.28%	46.96%	↑
Comprehensive Diabetes Care—LDL-C Screening	79.07%	81.07%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.67%	78.97%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	42.33%	41.36%	↔

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

Table D.12—CalViva Health—Fresno HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	7.69%	7.78%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	42.99	47.62	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	435.84	458.67	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.26%	83.64%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	79.47%	81.23%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months	97.90%	96.57%	↓
Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years	91.52%	91.06%	↓
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years	91.65%	91.33%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years	90.67%	87.45%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	53.16%	52.07%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	43.20%	43.80%	↔
Comprehensive Diabetes Care—HbA1c Testing	78.64%	79.32%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	44.17%	36.50%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.98%	26.28%	↓
Comprehensive Diabetes Care—LDL-C Screening	71.60%	66.42%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.20%	69.83%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	49.76%	57.18%	▼

*Member months are a member’s “contribution” to the total yearly membership.

Table D.13—CalViva Health—Kings HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	5.00%	S	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	53.80	55.66	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	419.16	403.24	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	74.65%	81.71%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	71.18%	74.56%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months	96.94%	94.85%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years	89.73%	83.44%	↓
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years	NA	86.92%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years	NA	84.55%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	48.28%	39.91%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.87%	37.22%	↔
Comprehensive Diabetes Care—HbA1c Testing	55.17%	78.92%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	32.02%	37.22%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	16.75%	28.25%	↑
Comprehensive Diabetes Care—LDL-C Screening	53.69%	73.54%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.41%	76.68%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	40.89%	55.61%	▼

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

Table D.14—CalViva Health—Madera HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	7.41%	S	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	48.98	49.54	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	425.90	464.83	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	76.08%	80.41%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	75.86%	81.42%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months	98.67%	98.06%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years	91.77%	93.38%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years	NA	92.84%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years	NA	90.76%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.78%	68.31%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.81%	59.08%	↑
Comprehensive Diabetes Care—HbA1c Testing	82.52%	88.00%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	44.98%	44.62%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.66%	33.23%	↔
Comprehensive Diabetes Care—LDL-C Screening	69.26%	74.46%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.35%	79.08%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	44.01%	47.69%	↔

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

Table D.15—Care 1st Partner Plan—San Diego HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	8.65%	8.64%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	43.32	44.72	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	249.97	237.00	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.85%	76.14%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	75.23%	72.65%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	93.78%	89.78%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	83.10%	81.31%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	82.68%	81.93%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	81.22%	79.34%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	63.36%	51.18%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	40.46%	41.34%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	83.21%	82.28%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	38.17%	35.04%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	35.11%	26.77%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	74.81%	70.47%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.92%	73.62%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	52.67%	71.65%	▼

*Member months are a member’s “contribution” to the total yearly membership.

Table D.16—CenCal Health—San Luis Obispo HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	6.70%	6.71%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	57.42	53.41	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	303.89	296.02	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	74.84%	71.79%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.57%	72.97%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months	95.37%	96.86%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years	86.59%	90.04%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years	87.92%	90.91%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years	87.58%	87.41%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	70.23%	67.71%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.91%	57.81%	↑
Comprehensive Diabetes Care—HbA1c Testing	75.81%	83.85%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	47.44%	50.00%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.56%	33.85%	↔
Comprehensive Diabetes Care—LDL-C Screening	73.95%	77.60%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.09%	80.73%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	48.37%	35.94%	▲

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

Table D.17—CenCal Health—Santa Barbara HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	5.54%	7.29%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	46.35	46.42	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	308.44	272.79	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.90%	79.54%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.97%	81.53%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	97.87%	98.48%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	91.26%	93.63%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	91.01%	92.99%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	89.25%	90.65%	↑
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	71.78%	71.53%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	64.96%	66.18%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	81.51%	84.18%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	56.45%	56.20%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	36.25%	36.98%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	76.16%	79.56%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.54%	81.02%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	38.69%	33.33%	↔

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

Table D.18—Central California Alliance for Health—Merced HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	9.86%	8.00%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	51.12	50.05	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	299.06	297.38	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	86.26%	82.92%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.96%	79.91%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	97.51%	97.66%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	90.37%	91.67%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	89.76%	90.11%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	90.30%	88.58%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	69.34%	50.85%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	49.88%	49.64%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	84.18%	85.16%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.26%	36.01%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	33.58%	25.06%	↓
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	81.75%	78.35%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.00%	78.83%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	45.50%	57.18%	▼

*Member months are a member’s “contribution” to the total yearly membership.

**Table D.19—Central California Alliance for Health—Monterey/Santa Cruz
HEDIS 2014 Non-SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	7.78%	7.69%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	49.10	44.17	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	293.93	282.10	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.15%	83.28%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.84%	80.85%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	98.50%	98.32%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	91.26%	92.06%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	90.86%	93.21%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	91.17%	91.08%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	76.16%	62.29%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	61.56%	51.09%	↓
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	85.64%	81.27%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	48.42%	40.15%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	38.20%	31.39%	↓
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	79.81%	73.97%	↓
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	76.16%	75.67%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	39.90%	50.36%	▼

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

**Table D.20—Community Health Group Partnership Plan—San Diego
HEDIS 2014 Non-SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	10.79%	10.38%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	34.30	35.06	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	287.97	280.48	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.91%	83.18%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.06%	81.92%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	97.34%	95.94%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	89.87%	89.97%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	89.76%	89.39%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	88.70%	85.50%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	65.69%	47.93%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	53.77%	51.34%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	86.86%	82.73%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	56.69%	43.31%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	38.69%	32.85%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	82.24%	77.86%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.05%	73.72%	↓
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	34.55%	42.82%	▼

*Member months are a member’s “contribution” to the total yearly membership.

Table D.21—Contra Costa Health Plan—Contra Costa HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	12.72%	9.53%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	55.98	48.06	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	199.28	223.77	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	78.37%	83.51%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	77.84%	84.67%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	86.81%	94.62%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	76.24%	86.03%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	77.74%	86.72%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	74.46%	83.50%	↑
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	59.85%	59.37%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	49.88%	45.74%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	81.27%	79.32%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	40.88%	35.28%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	33.58%	32.12%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	76.16%	69.83%	↓
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	75.91%	74.94%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	51.34%	54.01%	↔

*Member months are a member’s “contribution” to the total yearly membership.

Table D.22—Gold Coast Health Plan—Ventura HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	11.32%	9.53%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	46.49	35.36	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	294.22	189.20	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.26%	87.52%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.15%	88.58%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	82.60%	97.46%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	63.12%	86.35%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	NA	82.53%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	NA	79.68%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	65.69%	60.83%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	44.04%	42.34%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	82.73%	84.43%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	37.71%	45.01%	↑
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	33.82%	25.30%	↓
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	77.37%	77.37%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.78%	75.67%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	54.99%	46.47%	▲

*Member months are a member’s “contribution” to the total yearly membership.

Table D.23—Health Net Community Solutions, Inc.—Kern HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	7.36%	9.35%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	47.99	48.90	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	196.35	359.51	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	70.82%	86.73%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	70.73%	82.89%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	89.99%	93.14%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	70.52%	79.32%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	68.00%	67.84%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	76.72%	67.83%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	49.14%	52.31%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	49.88%	44.53%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	68.64%	78.10%	↑
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	32.84%	27.25%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	28.89%	25.06%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	64.20%	70.56%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	75.56%	76.16%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	59.01%	64.48%	↔

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

**Table D.24—Health Net Community Solutions, Inc.—Los Angeles
HEDIS 2014 Non-SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	7.58%	6.53%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	33.35	32.38	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	248.68	277.13	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	74.64%	77.70%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	83.33%	80.00%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	72.64%	76.55%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	94.35%	94.70%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	81.21%	81.27%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	83.10%	82.04%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	83.01%	77.67%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	53.04%	64.72%	↑
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	51.09%	51.34%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	78.83%	81.75%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	35.04%	39.66%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	31.63%	30.90%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	75.91%	74.94%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	81.27%	80.29%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	51.34%	50.85%	↔

*Member months are a member’s “contribution” to the total yearly membership.

**Table D.25—Health Net Community Solutions, Inc.—Sacramento
HEDIS 2014 Non-SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	6.02%	9.16%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	39.84	39.23	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	274.99	293.32	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	61.52%	67.61%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	56.74%	63.48%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	92.71%	92.50%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	80.23%	81.11%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	80.41%	79.18%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	81.67%	75.14%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	50.12%	49.39%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	36.98%	35.77%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	72.51%	71.29%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	39.66%	38.44%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	23.60%	26.28%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	59.61%	63.75%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	72.51%	71.53%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	51.34%	54.99%	↔

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

Table D.26—Health Net Community Solutions, Inc.—San Diego HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	9.38%	7.87%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	46.14	41.81	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	296.72	362.03	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	76.98%	83.47%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	75.42%	78.26%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months	94.45%	96.17%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years	85.41%	88.28%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years	84.87%	86.55%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years	82.60%	82.56%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	50.18%	46.58%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.67%	47.26%	↔
Comprehensive Diabetes Care—HbA1c Testing	78.49%	68.49%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	43.01%	34.93%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.32%	25.34%	↔
Comprehensive Diabetes Care—LDL-C Screening	68.82%	63.01%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	70.97%	69.86%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	48.75%	56.16%	↔

*Member months are a member’s “contribution” to the total yearly membership.

**Table D.27—Health Net Community Solutions, Inc.—San Joaquin
HEDIS 2014 Non-SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	—	NA	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	46.94	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	256.64	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	57.45%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	—	91.89%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	—	76.48%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	—	NA	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	—	NA	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	—	36.51%	Not Comparable
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	—	34.92%	Not Comparable
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	—	60.32%	Not Comparable
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	—	20.63%	Not Comparable
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	—	17.46%	Not Comparable
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	—	60.32%	Not Comparable
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	—	76.19%	Not Comparable
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	—	74.60%	Not Comparable

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

Table D.28—Health Net Community Solutions, Inc.—Stanislaus HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	5.66%	S	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	50.77	56.78	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	350.80	378.60	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.65%	81.05%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.25%	79.47%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months	97.12%	95.53%	↓
Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years	87.18%	85.74%	↓
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years	84.96%	86.32%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years	85.74%	83.89%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58.30%	63.99%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	45.56%	41.61%	↔
Comprehensive Diabetes Care—HbA1c Testing	85.33%	82.97%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	50.19%	46.23%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.34%	34.06%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.83%	73.48%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.13%	71.05%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	36.29%	42.09%	↔

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

Table D.29—Health Net Community Solutions, Inc.—Tulare HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	5.79%	9.62%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	37.86	38.64	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	449.45	486.43	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.16%	85.29%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	79.55%	81.40%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	97.78%	97.57%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	92.30%	92.05%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	91.58%	91.06%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	93.09%	89.35%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	58.64%	60.34%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	43.55%	40.88%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	84.43%	79.08%	↓
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	44.53%	41.61%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	30.90%	28.47%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	73.97%	71.78%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	79.81%	71.53%	↓
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	45.50%	51.09%	↔

*Member months are a member’s “contribution” to the total yearly membership.

Table D.30—Health Plan of San Joaquin—San Joaquin HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	6.27%	6.86%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	43.01	42.34	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	246.24	223.43	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	80.70%	81.28%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.44%	80.14%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	97.51%	97.00%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	87.52%	87.86%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	85.55%	86.67%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	84.77%	83.07%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	60.34%	59.61%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	42.58%	41.85%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	77.62%	72.02%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.99%	43.80%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	27.74%	32.12%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	71.29%	68.86%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	76.40%	68.37%	↓
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	47.20%	47.69%	↔

*Member months are a member’s “contribution” to the total yearly membership.

Table D.31—Health Plan of San Joaquin—Stanislaus HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	—	8.67%	Not Comparable
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	—	51.51	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	—	244.19	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	—	80.48%	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	—	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	—	84.05%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	—	97.21%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	—	88.33%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	—	88.87%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	—	86.62%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	—	66.58%	Not Comparable
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	—	31.78%	Not Comparable
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	—	83.01%	Not Comparable
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	—	48.22%	Not Comparable
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	—	39.73%	Not Comparable
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	—	72.33%	Not Comparable
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	—	76.16%	Not Comparable
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	—	41.37%	Not Comparable

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

Table D.32—Health Plan of San Mateo—San Mateo HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	19.24%	11.52%	▲
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	49.86	44.87	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	405.92	326.37	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.52%	83.57%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	84.70%	82.05%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	96.98%	97.15%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	88.77%	90.80%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	90.72%	90.92%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	87.60%	86.89%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	13.38%	52.31%	↑
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	32.36%	50.36%	↑
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	78.35%	81.75%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	46.47%	47.93%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	30.90%	36.50%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	69.34%	75.43%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	73.97%	82.00%	↑
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	35.52%	43.07%	▼

*Member months are a member’s “contribution” to the total yearly membership.

**Table D.33—Inland Empire Health Plan—Riverside/San Bernardino
HEDIS 2014 Non-SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	9.82%	9.67%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	48.29	44.44	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	308.23	247.47	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.14%	82.43%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	96.23%	85.19%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.24%	80.92%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	96.76%	96.70%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	86.92%	86.81%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	82.97%	84.46%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	86.73%	84.06%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	68.19%	67.26%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	52.94%	46.46%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	79.74%	78.98%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	42.70%	42.48%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	34.64%	34.29%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	76.03%	76.33%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	75.60%	75.44%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	46.19%	49.56%	↔

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

Table D.34—Kaiser North—Sacramento HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	11.63%	12.14%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	49.88	41.86	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	347.03	313.74	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.80%	93.08%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	90.72%	91.16%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	98.34%	99.48%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	90.10%	88.06%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	91.52%	83.92%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	92.23%	85.09%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	82.01%	79.51%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	65.24%	58.49%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	91.46%	91.64%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	50.61%	46.09%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	57.62%	54.99%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	89.94%	90.30%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	85.67%	89.49%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	34.45%	38.01%	↔

*Member months are a member’s “contribution” to the total yearly membership.

Table D.35—Kaiser South—San Diego HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	6.67%	11.46%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	35.60	26.61	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	415.75	343.04	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	91.74%	90.99%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	91.46%	91.03%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	99.51%	99.50%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	94.23%	93.49%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	95.14%	89.42%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	97.23%	87.65%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	87.01%	88.89%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	71.43%	79.06%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	94.81%	96.15%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	63.64%	61.97%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	60.61%	58.12%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	90.91%	92.74%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	90.91%	92.74%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	23.38%	21.37%	↔

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

Table D.36—Kern Family Health Care—Kern HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	6.27%	11.62%	▼
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	48.21	46.93	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	240.89	248.15	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	85.38%	88.05%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	85.34%	88.03%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	92.43%	93.25%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	82.13%	84.37%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	79.38%	81.42%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	82.19%	80.64%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	75.73%	76.89%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	43.98%	47.20%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	77.37%	80.29%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	46.53%	46.72%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	31.39%	34.79%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	72.99%	77.37%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	76.09%	79.81%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	46.35%	47.69%	↔

*Member months are a member’s “contribution” to the total yearly membership.

Table D.37—L.A. Care Health Plan—Los Angeles HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	10.99%	9.19%	▲
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	27.42	32.50	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	169.83	294.71	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	72.80%	78.24%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	75.57%	89.77%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	71.64%	77.33%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	91.20%	91.98%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	82.97%	82.88%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	87.12%	83.93%	↓
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	85.96%	79.56%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	57.66%	48.66%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	43.55%	43.31%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	79.56%	80.78%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	41.61%	38.20%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	29.68%	36.25%	↑
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	75.67%	79.32%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	76.64%	80.05%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	48.42%	51.82%	↔

*Member months are a member’s “contribution” to the total yearly membership.

**Table D.38—Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino
HEDIS 2014 Non-SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	9.17%	8.46%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	40.14	35.41	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	247.94	192.15	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.14%	83.84%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.14%	81.00%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	93.77%	92.80%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	83.13%	85.22%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	81.88%	85.22%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	84.55%	84.03%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	67.63%	54.97%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	46.89%	42.16%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	84.23%	79.69%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	42.32%	34.88%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	37.76%	30.91%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	84.65%	76.82%	↓
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	83.40%	76.38%	↓
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	46.06%	54.53%	▼

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

**Table D.39—Molina Healthcare of California Partner Plan, Inc.—Sacramento
HEDIS 2014 Non-SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	9.02%	7.34%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	42.97	44.36	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	218.18	204.58	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	71.60%	77.06%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	70.51%	75.81%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	94.90%	94.72%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	84.18%	83.98%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	83.64%	83.01%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	84.55%	81.09%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	57.40%	42.49%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	44.84%	44.02%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	74.44%	74.81%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	38.12%	39.44%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	27.35%	28.75%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	64.13%	68.70%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	71.30%	72.77%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	50.22%	50.89%	↔

*Member months are a member’s “contribution” to the total yearly membership.

**Table D.40—Molina Healthcare of California Partner Plan, Inc.—San Diego
HEDIS 2014 Non-SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	9.37%	8.52%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	43.19	35.84	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	273.91	197.22	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.63%	81.81%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.40%	82.50%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	96.16%	95.85%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	88.11%	88.86%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	88.25%	89.22%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	85.32%	86.40%	↑
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	60.21%	55.85%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	45.42%	43.27%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	81.69%	82.78%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	46.83%	45.03%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	33.80%	34.22%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	72.18%	76.38%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	71.13%	76.38%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	42.25%	47.02%	↔

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

Table D.41—Partnership HealthPlan of California—Marin HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP measure	3.70%	S	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	45.40	40.32	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	275.93	308.78	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	67.24%	82.76%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	65.91%	84.09%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months	98.75%	99.10%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years	87.92%	90.78%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years	NA	87.41%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years	NA	85.57%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.82%	74.70%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.03%	49.40%	↔
Comprehensive Diabetes Care—HbA1c Testing	84.62%	84.34%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	39.74%	44.58%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	30.77%	30.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	65.38%	73.49%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	70.51%	77.11%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	50.00%	45.78%	↔

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

Table D.42—Partnership HealthPlan of California—Mendocino HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	8.03%	S	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	51.97	50.11	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	289.83	267.41	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	79.55%	80.58%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	78.57%	78.46%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	95.44%	95.78%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	89.08%	88.55%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	NA	88.58%	Not Comparable
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	NA	88.52%	Not Comparable
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	61.25%	62.44%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	31.88%	31.47%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	95.63%	81.73%	↓
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	45.00%	35.53%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	32.50%	23.86%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	75.00%	62.44%	↓
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	71.25%	67.51%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	40.00%	54.82%	▼

*Member months are a member’s “contribution” to the total yearly membership.

**Table D.43—Partnership HealthPlan of California—Napa/Solano/Yolo
HEDIS 2014 Non-SPD Trend Table**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	6.84%	7.48%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	47.01	45.79	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	274.50	240.94	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	78.93%	84.91%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	74.90%	83.24%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	96.69%	96.88%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	86.57%	87.88%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	83.59%	85.88%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	85.36%	84.15%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	69.54%	69.83%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	52.54%	50.85%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	87.64%	82.24%	↓
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	49.67%	47.93%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	37.75%	36.98%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	78.15%	75.43%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.12%	81.27%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	37.75%	41.61%	↔

*Member months are a member’s “contribution” to the total yearly membership.

Table D.44—Partnership HealthPlan of California—Sonoma HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	7.01%	9.54%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	38.92	34.76	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	306.38	319.83	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	68.61%	80.70%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	62.90%	81.87%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	96.29%	98.27%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	88.48%	90.28%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	85.78%	87.13%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	88.24%	86.68%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	73.95%	78.80%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	52.99%	57.61%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	90.12%	91.58%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	48.50%	50.82%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	37.43%	40.49%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	78.14%	80.16%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	79.04%	78.80%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	37.72%	36.14%	↔

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

Table D.45—San Francisco Health Plan—San Francisco HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	7.59%	5.69%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	24.57	23.26	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	300.16	330.07	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	73.62%	86.25%	↑
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	74.36%	83.72%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	95.91%	97.04%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	89.65%	92.69%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	93.25%	94.85%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	91.27%	91.16%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	76.39%	76.80%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	69.68%	69.14%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	90.97%	88.63%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	61.11%	66.13%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	48.61%	51.04%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	81.25%	80.51%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	85.88%	85.38%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	27.78%	22.27%	↔

*Member months are a member’s “contribution” to the total yearly membership.

Table D.46—Santa Clara Family Health Plan—Santa Clara HEDIS 2014 Non-SPD Trend Table

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP measure</i>	8.26%	8.29%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	33.44	30.95	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	244.89	240.37	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	84.67%	82.83%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	NA	NA	Not Comparable
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	83.20%	81.68%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>	96.87%	97.31%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>	88.91%	88.94%	↔
<i>Children & Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>	88.91%	90.52%	↑
<i>Children & Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>	87.74%	87.49%	↔
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	55.72%	58.64%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	38.20%	47.45%	↑
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	82.73%	80.29%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>	48.18%	48.42%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>	35.77%	36.74%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	73.72%	72.75%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	74.94%	77.86%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>	41.61%	40.63%	↔

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

Appendix E. **MEDI-CAL MANAGED CARE HEDIS 2014 AT-A-GLANCE
PERFORMANCE SUMMARY**

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

Table E.1—HEDIS Performance Measures Name Key

Abbreviation	Full Name
AAB	<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i>
CAP-1224	<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months</i>
CAP-256	<i>Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years</i>
CAP-711	<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years</i>
CAP-1219	<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years</i>
CCS	<i>Cervical Cancer Screening</i>
CDC-BP	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>
CDC-E	<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>
CDC-H8	<i>Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)</i>
CDC-H9	<i>Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)</i>
CDC-HT	<i>Comprehensive Diabetes Care—HbA1 Testing</i>
CDC-LC	<i>Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)</i>
CDC-LS	<i>Comprehensive Diabetes Care—LDL-C Screening</i>
CDC-N	<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>
CIS-3	<i>Childhood Immunization Status—Combination 3</i>
IMA-CO1	<i>Immunizations for Adolescents—Combination 1</i>
LBP	<i>Use of Imaging Studies for Low Back Pain</i>
MPM-ACE	<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>
MPM-DIG	<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>
MPM-DIU	<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>
PPC-Pre	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>
PPC-Pst	<i>Prenatal and Postpartum Care—Postpartum Care</i>
WCC-BMI	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total</i>
WCC-N	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total</i>
WCC-PA	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total</i>
W34	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>

Note: AMB-ED, AMB-OP, MPM-ACE, CBP, and MMA are not presented in the tables of this appendix because MPLs and HPLs were not applied to these measures in 2013.

Tables E.2 and E.3 provide a summary of each full-scope MCP’s rates for each measure relative to the DHCS-established MPLs and HPLs. Although the tables reflect all 2014 rates that were below the MPL and above the HPL, MCPs are not held to the MPLs in the following cases: (1) for first-year measures, (2) for measures that had significant specification changes impacting comparability, or (3) if DHCS decided to prioritize efforts in other areas of poor performance.

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

Managed Care Plan Name	County	Total Measures Below MPLs	Total Measures at or Above HPLs
Alameda Alliance for Health	Alameda	10	2
Alameda Alliance for Health Total		10	2
Anthem Blue Cross Partnership Plan	Alameda	22	1
Anthem Blue Cross Partnership Plan	Contra Costa	16	2
Anthem Blue Cross Partnership Plan	Fresno	13	1
Anthem Blue Cross Partnership Plan	Kings	19	1
Anthem Blue Cross Partnership Plan	Madera	7	2
Anthem Blue Cross Partnership Plan	Sacramento	15	1
Anthem Blue Cross Partnership Plan	San Francisco	7	3
Anthem Blue Cross Partnership Plan	Santa Clara	7	0
Anthem Blue Cross Partnership Plan	Tulare	2	1
Anthem Blue Cross Partnership Plan Total		108	12
CalOptima	Orange	0	7
CalOptima Total		0	7
CalViva Health	Fresno	4	2
CalViva Health	Kings	14	0
CalViva Health	Madera	5	1
CalViva Health Total		23	3
Care1st Partner Plan	San Diego	11	0
Care1st Partner Plan Total		11	0
CenCal Health	San Luis Obispo	2	1
CenCal Health	Santa Barbara	1	5
CenCal Health Total		3	6
Central California Alliance for Health	Merced	1	2
Central California Alliance for Health	Monterey/Santa Cruz	0	6
Central California Alliance for Health Total		1	8
Community Health Group Partnership Plan	San Diego	2	5
Community Health Group Partnership Plan Total		2	5

Managed Care Plan Name	County	Total Measures Below MPLs	Total Measures at or Above HPLs
Contra Costa Health Plan	Contra Costa	6	3
Contra Costa Health Plan Total		6	3
Gold Coast Health Plan	Ventura	6	0
Gold Coast Health Plan Total		6	0
Health Net Community Solutions, Inc.	Kern	16	2
Health Net Community Solutions, Inc.	Los Angeles	9	2
Health Net Community Solutions, Inc.	Sacramento	16	2
Health Net Community Solutions, Inc.	San Diego	12	2
Health Net Community Solutions, Inc.	San Joaquin	15	0
Health Net Community Solutions, Inc.	Stanislaus	8	1
Health Net Community Solutions, Inc.	Tulare	2	1
Health Net Community Solutions, Inc., Total		78	10
Health Plan of San Joaquin	San Joaquin	5	1
Health Plan of San Joaquin	Stanislaus	8	0
Health Plan of San Joaquin Total		13	1
Health Plan of San Mateo	San Mateo	3	3
Health Plan of San Mateo Total		3	3
Inland Empire Health Plan	Riverside/San Bernardino	2	0
Inland Empire Health Plan Total		2	0
Kaiser North	Sacramento	2	22
Kaiser North Total		2	22
Kaiser South	San Diego	0	20
Kaiser South Total		0	20
Kern Family Health Care	Kern	5	1
Kern Family Health Care Total		5	1
L.A. Care Health Plan	Los Angeles	8	2
L.A. Care Health Plan Total		8	2
Molina Healthcare of California Partner Plan, Inc.	Riverside/San Bernardino	9	1
Molina Healthcare of California Partner Plan, Inc.	Sacramento	13	0
Molina Healthcare of California Partner Plan, Inc.	San Diego	2	0
Molina Healthcare of California Partner Plan, Inc., Total		24	1

Managed Care Plan Name	County	Total Measures Below MPLs	Total Measures at or Above HPLs
Partnership HealthPlan of California	Marin	3	4
Partnership HealthPlan of California	Mendocino	7	3
Partnership HealthPlan of California	Napa/Solano/Yolo	2	5
Partnership HealthPlan of California	Sonoma	2	5
Partnership HealthPlan of California Total		14	17
San Francisco Health Plan	San Francisco	0	14
San Francisco Health Plan Total		0	14
Santa Clara Family Health Plan	Santa Clara	0	2
Santa Clara Family Health Plan Total		0	2

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

- Measures below MPL
- Measures at or above HPL

Table E.3—Medi-Cal Managed Care HEDIS 2014 Performance Summary

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

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

Health Plan Name	County	CDC-H8	CDC-BP	CDC-LC	CDC-E	CDC-LS	CDC-N	CDC-H9	CDC-HT
Alameda Alliance for Health	Alameda								
Anthem Blue Cross Partnership Plan	Alameda	●	●	●	●	●	●	●	●
Anthem Blue Cross Partnership Plan	Contra Costa	●	●		●	●		●	●
Anthem Blue Cross Partnership Plan	Fresno	●	●						
Anthem Blue Cross Partnership Plan	Kings	●		●	●	●		●	●
Anthem Blue Cross Partnership Plan	Madera					●			
Anthem Blue Cross Partnership Plan	Sacramento		●		●	●			●
Anthem Blue Cross Partnership Plan	San Francisco					●			
Anthem Blue Cross Partnership Plan	Santa Clara		●						
Anthem Blue Cross Partnership Plan	Tulare								
CalOptima	Orange	○		○	○	○			
CalViva Health	Fresno	●						●	
CalViva Health	Kings	●	●						●
CalViva Health	Madera								
Care1st Partner Plan	San Diego		●		●				
CenCal Health	San Luis Obispo							○	
CenCal Health	Santa Barbara	○			○				
Central California Alliance for Health	Merced								
Central California Alliance for Health	Monterey/Santa Cruz		○						
Community Health Group Partnership Plan	San Diego		●						
Contra Costa Health Plan	Contra Costa								
Gold Coast Health Plan	Ventura								
Health Net Community Solutions, Inc.	Kern	●	●		●			●	●
Health Net Community Solutions, Inc.	Los Angeles								
Health Net Community Solutions, Inc.	Sacramento		●		●	●			●
Health Net Community Solutions, Inc.	San Diego	●	●			●		●	●
Health Net Community Solutions, Inc.	San Joaquin	●	●		●	●		●	●

Health Plan Name	County	CDC-H8	CDC-BP	CDC-LC	CDC-E	CDC-LS	CDC-N	CDC-H9	CDC-HT
Health Net Community Solutions, Inc.	Stanislaus				●				
Health Net Community Solutions, Inc.	Tulare					●			
Health Plan of San Joaquin	San Joaquin								●
Health Plan of San Joaquin	Stanislaus				●				
Health Plan of San Mateo	San Mateo		●				○		
Inland Empire Health Plan	Riverside/San Bernardino								
Kaiser North	Sacramento	○	○	○		○	○	○	○
Kaiser South	San Diego	○	○	○	○	○	○	○	○
Kern Family Health Care	Kern		○						
L.A. Care Health Plan	Los Angeles								
Molina Healthcare of California Partner Plan, Inc.	Riverside/San Bernardino	●							
Molina Healthcare of California Partner Plan, Inc.	Sacramento		●						
Molina Healthcare of California Partner Plan, Inc.	San Diego								
Partnership HealthPlan of California	Marin								
Partnership HealthPlan of California	Mendocino				●	●			
Partnership HealthPlan of California	Napa/Solano/Yolo			○			○		
Partnership HealthPlan of California	Sonoma								
San Francisco Health Plan	San Francisco	○	○	○			○	○	
Santa Clara Family Health Plan	Santa Clara								

Health Plan Name	County	CIS-3	IMA-CO1	LBP	MMA-50	MMA-75	MPM-ACE	MPM-DIG	MPM-DIU
Alameda Alliance for Health	Alameda			○	●	●	●		
Anthem Blue Cross Partnership Plan	Alameda			○	●	●	●		●
Anthem Blue Cross Partnership Plan	Contra Costa			○	●	●	●		●
Anthem Blue Cross Partnership Plan	Fresno			○	●	●	●		●
Anthem Blue Cross Partnership Plan	Kings			○	●	●	●		●
Anthem Blue Cross Partnership Plan	Madera	●		○	●	●	●		●
Anthem Blue Cross Partnership Plan	Sacramento	●		○			●		●
Anthem Blue Cross Partnership Plan	San Francisco			○	●		●		
Anthem Blue Cross Partnership Plan	Santa Clara				●				
Anthem Blue Cross Partnership Plan	Tulare			○	●	●			
CalOptima	Orange								
CalViva Health	Fresno				●			●	
CalViva Health	Kings								
CalViva Health	Madera			●	●		●		
Care1st Partner Plan	San Diego	●					●		
CenCal Health	San Luis Obispo						●		
CenCal Health	Santa Barbara	○						●	
Central California Alliance for Health	Merced			○				●	
Central California Alliance for Health	Monterey/Santa Cruz			○					
Community Health Group Partnership Plan	San Diego							○	
Contra Costa Health Plan	Contra Costa			○	●			○	
Gold Coast Health Plan	Ventura								
Health Net Community Solutions, Inc.	Kern	●					●		●
Health Net Community Solutions, Inc.	Los Angeles						●	●	●
Health Net Community Solutions, Inc.	Sacramento	●		○		○	●	●	●
Health Net Community Solutions, Inc.	San Diego			●		○			
Health Net Community Solutions, Inc.	San Joaquin						●		●

Health Plan Name	County	CIS-3	IMA-CO1	LBP	MMA-50	MMA-75	MPM-ACE	MPM-DIG	MPM-DIU
Health Net Community Solutions, Inc.	Stanislaus		●				●		
Health Net Community Solutions, Inc.	Tulare			○					
Health Plan of San Joaquin	San Joaquin			○	●		●		
Health Plan of San Joaquin	Stanislaus	●				●			
Health Plan of San Mateo	San Mateo								○
Inland Empire Health Plan	Riverside/San Bernardino								
Kaiser North	Sacramento	○	○	○	○	○	○		○
Kaiser South	San Diego	○		○	○		○		○
Kern Family Health Care	Kern								
L.A. Care Health Plan	Los Angeles				○	○	●	●	●
Molina Healthcare of California Partner Plan, Inc.	Riverside/San Bernardino				●			○	
Molina Healthcare of California Partner Plan, Inc.	Sacramento	●					●	●	●
Molina Healthcare of California Partner Plan, Inc.	San Diego			●				●	
Partnership HealthPlan of California	Marin			○	●				
Partnership HealthPlan of California	Mendocino	●	●	○	○		●		●
Partnership HealthPlan of California	Napa/Solano/Yolo			○	○	○			
Partnership HealthPlan of California	Sonoma			○		○	●		
San Francisco Health Plan	San Francisco	○		○				○	
Santa Clara Family Health Plan	Santa Clara			○		○			

Health Plan Name	County	PPC-Pst	PPC-Pre	W3 4	WCC-BMI	WCC-N	WCC-PA
Alameda Alliance for Health	Alameda	●	●				
Anthem Blue Cross Partnership Plan	Alameda	●	●	●		●	
Anthem Blue Cross Partnership Plan	Contra Costa	●	●				
Anthem Blue Cross Partnership Plan	Fresno	●	●				
Anthem Blue Cross Partnership Plan	Kings	●		●		●	
Anthem Blue Cross Partnership Plan	Madera		●	○			
Anthem Blue Cross Partnership Plan	Sacramento	●	●				
Anthem Blue Cross Partnership Plan	San Francisco	●	●				○
Anthem Blue Cross Partnership Plan	Santa Clara					●	●
Anthem Blue Cross Partnership Plan	Tulare						
CalOptima	Orange			○		○	○
CalViva Health	Fresno			○			
CalViva Health	Kings	●		●	●	●	
CalViva Health	Madera	●		○			
Care1st Partner Plan	San Diego			●			
CenCal Health	San Luis Obispo						
CenCal Health	Santa Barbara	○					
Central California Alliance for Health	Merced				○		
Central California Alliance for Health	Monterey/Santa Cruz		○		○	○	○
Community Health Group Partnership Plan	San Diego				○	○	○
Contra Costa Health Plan	Contra Costa						
Gold Coast Health Plan	Ventura			●		●	●
Health Net Community Solutions, Inc.	Kern	●	●			○	○
Health Net Community Solutions, Inc.	Los Angeles	●	●			○	○
Health Net Community Solutions, Inc.	Sacramento	●	●				
Health Net Community Solutions, Inc.	San Diego	●	●				○

Health Plan Name	County	PPC-Pst	PPC-Pre	W3 4	WCC-BMI	WCC-N	WCC-PA
Health Net Community Solutions, Inc.	San Joaquin	●	●	●			
Health Net Community Solutions, Inc.	Stanislaus	●					○
Health Net Community Solutions, Inc.	Tulare						
Health Plan of San Joaquin	San Joaquin						
Health Plan of San Joaquin	Stanislaus	●	●			●	
Health Plan of San Mateo	San Mateo						
Inland Empire Health Plan	Riverside/San Bernardino						
Kaiser North	Sacramento		○		○	○	○
Kaiser South	San Diego				○	○	○
Kern Family Health Care	Kern			●			
L.A. Care Health Plan	Los Angeles	●					
Molina Healthcare of California Partner Plan, Inc.	Riverside/San Bernardino	●	●				
Molina Healthcare of California Partner Plan, Inc.	Sacramento	●	●	●			
Molina Healthcare of California Partner Plan, Inc.	San Diego						
Partnership HealthPlan of California	Marin				○		
Partnership HealthPlan of California	Mendocino			●			
Partnership HealthPlan of California	Napa/Solano/Yolo						
Partnership HealthPlan of California	Sonoma	○			○		
San Francisco Health Plan	San Francisco		○	○	○	○	○
Santa Clara Family Health Plan	Santa Clara						