Medi-Cal Managed Care Technical Report

July 1, 2012–June 30, 2013

Medi-Cal Managed Care 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
- **CAHPS®**—Consumer Assessment of Healthcare Providers and Systems[1]
- **CFR**—Code of Federal Regulations
- **CMS**—Centers for Medicare & Medicaid Services
- **COHS**—County-Organized Health System
- **CP**—commercial plan
- **DHCS** —California Department of Health Care Services
- **DMHC**—California Department of Managed Health Care
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **FFS**—fee-for-service
- **GMC**—Geographic Managed Care
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[2]
- **HFP**—Healthy Families Program
- **HPL**—high performance level
- **HSAG**—Health Services Advisory Group, Inc.
- **IOM**—Institute of Medicine
- **IP**—improvement plan
- **LI**—Local Initiative
- **MCMC**—Medi-Cal Managed Care program
- **MCP**—managed care plan
- **MER**—Medical Exemption Request
- **MPL**—minimum performance level
- **NCQA**—National Committee for Quality Assurance
- **Non-SPD**—Non-Seniors and Persons with Disabilities
- **QIP**—quality improvement project
- **SPD**—Seniors and Persons with Disabilities
- **TPM**—Two-Plan Model

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

1. Executive Summary

As required by the Code of Federal Regulations (CFR) at Title 42, Section (§) 438.364, the Department of Health Care Services (DHCS) contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services provided by California's Medi-Cal managed care plans (MCPs). This report provides an assessment of the MCPs' strengths and weaknesses with respect to the quality and timeliness of, and access to, the health care services they furnished to California's Medicaid recipients; provides recommendations for improvement; and assesses the degree to which the MCPs addressed previous recommendations.

HSAG's performance evaluation centers on federal and State-specified criteria that fall into one or more domains of care: quality, access, and timeliness for each part of the compliance review, each performance measure, each quality improvement project (QIP), and two optional EQR activities—member satisfaction survey results and encounter data validation results.

Although HSAG identified opportunities for improvement in all areas assessed, overall, the Medi-Cal Managed Care program (MCMC) and its contracted MCPs implemented initiatives that resulted in the provision of quality, accessible, and timely health care services to MCMC beneficiaries.

Overall Recommendations

Based on its assessment, HSAG provides the following recommendations for MCPs across all activities:

- Ensure that policies and procedures reflect all federal and State requirements. Additionally, ensure that these policies and procedures are implemented and monitored.
- Use data to drive quality improvement efforts and implement strategies that have the ability to improve health outcomes.
- Identify and focus on high-priority areas for improvement to increase the likelihood that improvement strategies will be successful, taking into account limited resources.
- Implement rapid cycle improvement strategies by conducting regular causal/barrier analyses; directly linking the improvement strategies to high-priority barriers; and assessing interim outcomes quarterly, at minimum, to determine if improvement strategies should be revised, standardized, scaled up, or discontinued.

- Select areas of poor performance as the focus for formal quality improvement projects (QIPs), when appropriate.

Based on its assessment, HSAG provides the following recommendations for MCMC across all activities:

- Continue to implement new monitoring and oversight protocols to ensure that each MCP complies with all federal and State requirements, including that each MCP undergoes a comprehensive audit at least once within a three-year period.
- Engage MCPs that display poor performance over consecutive years in intensive oversight (at least quarterly), and require these MCPs to develop formal corrective action plans to address their poor performance.
- Identify State-level barriers related to MCMC performance, and develop and implement strategies to address these barriers.

Note: HSAG provides detailed findings, conclusions, and recommendations for each of the assessed activities in the activity-specific sections of this report and in the Overall Findings, Conclusions, and Recommendations Related to External Quality Review Activities section.

Report Organization

This report includes nine sections, providing an aggregate assessment of health care timeliness, access, and quality based on MCP performance across compliance, performance measures, quality improvement projects, member satisfaction surveys, and encounter data activities.

Section 1—Executive Summary includes a high-level summary of external quality review results.

Section 2—Introduction describes the purpose of the report and provides an overview of MCMC, a summary of its service delivery system, and the assignment of domains of care.

Section 3—Medi-Cal Managed Care Quality Strategy summarizes the quality assessment and performance improvement strategy goals and objectives for MCMC.

Section 4—Health Plan Compliance

Section 5—Performance Measures

Section 6—Quality Improvement Projects

Sections 4, 5, and 6 describe each of the three mandatory activities, HSAG's objectives and methodology for conducting the required activities, HSAG's methodology for aggregation and analysis of data, and an assessment of overall MCP strengths and opportunities for improvement.

Section 7—Member Satisfaction Survey

Section 8—Encounter Data Validation

Sections 7 and 8 describe two optional activities, HSAG's objectives and methodology for conducting the activities, HSAG's methodology for aggregation and analysis of data, and an assessment of overall MCP strengths and opportunities for improvement.

Section 9—Overall Findings, Conclusions, and Recommendations Related to External Quality Review Activities summarizes MCPs' performance for each of the review activities.

Section 10—Overall Findings, Conclusions, and Recommendations Related to Domains of Care summarizes MCPs' performance related to the quality, access, and timeliness domains of care.

Appendix A—Individual Managed Care Plan Performance Measure Results

Appendix B—Individual Full-Scope Managed Care Plan SPD and non-SPD Rates

Appendix C—Individual Managed Care Plan Quality Improvement Project Information

Appendix D—Individual Full-Scope Managed Care Plan Member Satisfaction Survey Results

Appendix E—Grid of 2011–12 EQR Recommendations and Medi-Cal Managed Care's Follow-Up provides the 2011–12 EQR recommendations and MCMC's actions that address the recommendations.

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal) through its fee-for-service and managed care delivery systems. DHCS's Medi-Cal Managed Care Division oversees the Medi-Cal managed care program (MCMC), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[3] through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

Section 438.364[4] of 42 CFR requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services provided by the states' Medicaid MCPs. The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to, health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

To comply with the CFR, DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to aggregate and analyze the MCP data and prepare an annual technical report.

HSAG's performance evaluation centers on federal and State-specified criteria that fall into one or more domains of care: quality, access, and timeliness for each part of the compliance review, each performance measure, and each quality improvement project (QIP). While not required, the State can elect to include optional EQR activities, such as member satisfaction survey results or encounter data validation results.

This report provides:

- A description of MCMC.
- A description of MCMC's quality strategy and quality improvement objectives as of June 2013.

[3] *Medi-Cal Managed Care Enrollment Report—June 2013.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.

[4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

- A description of the scope of external quality review (EQR) activities for the period of July 1, 2012, through June 30, 2013, including the methodology used for data collection and analysis and a description of the data for each activity.
- An aggregate assessment of health care timeliness, access, and quality across organizational structure and health plan compliance based on performance measures, QIPs, and member satisfaction surveys. In addition, the report includes other optional EQR monitoring activities, such as encounter data validation results that help evaluate the MCPs' infrastructure to collect and report on services received so that these data can be used to inform quality improvement activities.

MCP-specific evaluation reports, issued in tandem with the technical report, provide plan-specific results in the areas of performance measures, QIPs, member satisfaction surveys, and encounter data validation. Each MCP-specific report provides an assessment of the MCP's strengths and opportunities for improvement regarding the quality and timeliness of, and access to, health care and services, as well as recommendations to the MCP for improving quality of health care services for its members. These reports are available on the DHCS website at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

Medi-Cal Managed Care Program Overview

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

DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards. During the review period, DHCS contracted with 22 full-scope MCPs and 3 specialty MCPs operating in 30 of California's 58 counties to provide services to approximately 5.6 million beneficiaries.[5] DHCS operates MCMC through a service delivery system that encompasses three different plan model types for its full-scope services: the Two-Plan Model (TPM)—both local initiative (LI) and commercial plan (CP), the Geographic Managed Care (GMC) model, and the County Organized Health Systems (COHS) model. DHCS monitors MCP performance across model types. Table 2.1 shows participating MCPs by model type.

[5] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Two-Plan

In most TPM counties, there is an LI and 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. MCMC beneficiaries may choose to enroll in the LI or the CP.

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.

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.

Specialty Managed Care Plans

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

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

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

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

Domains of Care

The Centers for Medicare & Medicaid Services (CMS) chose the domains of quality, access, and timeliness as keys to evaluating the performance of MCPs. HSAG used the following definitions to evaluate and draw conclusions about the performance of the plans in each of these domains.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[6]

Access

In the preamble to the CFR,[7] CMS discusses access to and the availability of services to Medicaid enrollees as the degree to which plans implement the standards set forth by the State to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that reflects the needs and characteristics of the enrollees served by the plan.

Timeliness

The National Committee for Quality Assurance (NCQA) defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[8] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCP—e.g., processing expedited appeals and providing timely follow-up care. The Agency for Healthcare Research and Quality (AHRQ) indicates "timeliness is the health care system's capacity to provide health care quickly after a need is recognized."[9]

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[6] This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

[7] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

[8] National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.

[9] Agency for Healthcare Research and Quality. *National Healthcare Quality Report* 2007. AHRQ Publication No. 08-0040. February 2008.

Timeliness includes the interval between identifying a need for specific tests and treatments and actually receiving those services.[10]

The table below shows HSAG's assignment of the compliance review standards, performance measures, QIPs, and CAHPS survey measures into the domains of quality, timeliness, and access.

Table 2.2—Assignment of Activities to Performance Domains

Compliance Review Standards*	Quality	Timeliness	Access
Enrollee Rights and Protections Standards		√	√
Access Standards		√	√
Structure and Operations Standards		√	√
Measurement and Improvement Standards	√		
Grievance System Standards		√	√
Performance Measures	**Quality**	**Timeliness**	**Access**
All-Cause Readmissions (internally developed measure)	√		√
Ambulatory Care—Emergency Department (ED) Visits‡	**	**	**
Ambulatory Care—Outpatient Visits‡	**	**	**
Annual Monitoring for Patients on Persistent Medications—ACE	√		
Annual Monitoring for Patients on Persistent Medications—Digoxin	√		
Annual Monitoring for Patients on Persistent Medications—Diuretics	√		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	√		
Breast Cancer Screening	√		√
Cervical Cancer Screening	√		√
Childhood Immunization Status—Combination 3	√	√	√
Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)			√
Children and Adolescents' Access to Primary Care Practitioner (25 Months–6 Years)			√
Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)			√
Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)			√
Colorectal Cancer Screening	√		√
Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)	√		
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	√		√
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)	√		
Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)	√		
Comprehensive Diabetes Care—HbA1c Testing	√		√
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	√		

[10] Ibid.

Performance Measures	Quality	Timeliness	Access
Comprehensive Diabetes Care—LDL-C Screening	√		√
Comprehensive Diabetes Care—Medical Attention for Nephropathy	√		√
Controlling High Blood Pressure	√		
Immunizations for Adolescents—Combination 1	√	√	√
Inpatient Hospitalizations	√		√
Medication Management for People with Asthma—Medication Compliance 50% Total	√		
Medication Management for People with Asthma—Medication Compliance 75% Total	√		
Osteoporosis Management in Women Who had a Fracture	√	√	
Out of Home Placements	√		√
Prenatal and Postpartum Care—Timeliness of Prenatal Care	√	√	√
Prenatal and Postpartum Care—Postpartum Care	√	√	√
Use of Imaging Studies for Low Back Pain	√		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	√	√	√
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	√		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	√		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	√		
Quality Improvement Projects	**Quality**	**Timeliness**	**Access**
All-Cause Readmissions	√		√
Internal QIPs	Domain varied by MCP project. See Appendix C for a list of all internal QIPs and the assigned domain of care.		
CAHPS Survey Measures	**Quality**	**Timeliness**	**Access**
Rating of Health Plan	√		
Rating of All Health Care	√		
Rating of Personal Doctor	√		
Rating of Specialist Seen Most Often	√		
Getting Needed Care	√		√
Getting Care Quickly	√	√	
How Well Doctors Communicate	√		
Customer Service	√		
Shared Decision Making	√		

‡This is a utilization measure.

*The compliance review standards related to managed care plans are defined at 42 CFR 438.

**Domains of care are not assigned to utilization measures.

Medi-Cal Managed Care Quality Strategy

Sections 438.200 and 438.202 of 42 CFR require that state Medicaid agencies develop and implement a written quality strategy for assessing and improving the quality of health care services offered to their beneficiaries. The written strategy must describe the standards the state and its contracted plans must meet. The State must conduct periodic reviews to examine the scope and content of its managed care quality strategy, evaluate the strategy's effectiveness, and update it as needed.

In June 2013, to comply with federal regulations, DHCS's Medi-Cal Managed Care Division issued an annual update to the *Medi-Cal Managed Care Program Quality Strategy Report*,[11] which reflects DHCS's renewed emphasis on quality and outcomes, and it outlines efforts designed to achieve the three aims, which are linked to the National Quality Strategy[12]:

1. Improve the health of all Californians.
2. Enhance the quality, including the patient care experience, of all DHCS programs.
3. Reduce DHCS's per-capita health care program costs.

The quality strategy report includes a description of the program background and structure, contractual standards, and oversight and monitoring activities. Additionally, this report outlines the operational processes implemented by MCMC to assess the quality of care, make improvements, obtain input from members and stakeholders, ensure compliance with State-established standards, and conduct periodic evaluation of the effectiveness of the strategy. The MCMC quality strategy aligns with the DHCS Quality Strategy, but it has an emphasis on strategies and objectives specific to MCMC.

Quality Strategy Goals

MCMC outlined the following goals in the 2013 annual update:

- Improve health and health outcomes for the Medi-Cal population.
- Improve the quality of care provided to Medi-Cal beneficiaries by contracted health plans.
- Increase access to appropriate health care services for all enrolled beneficiaries.

[11] *Medi-Cal Managed Care Program Quality Strategy Report—Annual Update, June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx#qualitystrategyreports
[12] National Quality Strategy. Available at: http://www.ahrq.gov/workingforquality/about.htm#aims

- Establish accountability for quality health care by implementing formal, systematic monitoring and evaluation of the quality of care and services provided to all Medi-Cal beneficiaries, including individuals with chronic conditions and special health care needs.
- Improve systems for providing care management and coordination for vulnerable populations, including seniors and persons of all ages with disabilities and special health care needs.

Quality Improvement Strategy Objectives

The *Medi-Cal Managed Care Program Quality Strategy Report* identifies the following objectives for MCMC:

- Establish a process by December 2013 to ensure that all beneficiaries enrolled in MCMC have access to a medical home and to increase access to medical homes through geographic managed care expansion into currently FFS-only counties.
- Implement one or more performance standards and measures that would require MCPs to evaluate and improve SPD health outcomes by HEDIS reporting year 2013.
- Complete COHS MCP contract revisions and align them with Two-Plan and GMC contracts that require enhanced case management and coordination of care services for SPD members identified as high-risk and a process for MCMC to monitor plan compliance by August 2013.
- Continue a statewide collaboration with MCPs through calendar year (CY) 2015 to reduce all-cause readmissions by addressing continuity of care and care transitions for adults 21 years and older, including SPDs and dual eligibles.
- Administer the 2013 CAHPS survey to all plans, with results available in early 2014.
- Establish a process by June 2013 for timely notification of MCPs that ensures that MCPs contact beneficiaries who have recently received a denial of their Medical Exemption Requests (MERs) for care coordination and to address any special needs.
- Coordinate activities that focus on the collection, analysis, and reporting for 16 of the *Initial Core Set of Adult Health Care Quality Measures for Medicaid-Eligible Adults* as part of the Adult Medicaid Quality Grant.
- Reduce the smoking rate among MCP members.
- Continue to consistently review the process to engage stakeholders and advocates in policy development.

Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

The *Medi-Cal Managed Care Program Quality Strategy Report* indicates that DHCS is responsible for the oversight and monitoring of access to MCMC services, quality of care delivered to MCP members, availability and timeliness of appropriate levels of care, and internal structural systems established by contracted MCPs. The strategy report outlines how DHCS reviews the findings and recommendations included in the *Medi-Cal Managed Care Technical Report* and indicates that DHCS informs the EQRO of any action items resulting from review of the report.

The *Medi-Cal Managed Care Technical Report* summarizes many quality-related initiatives that assist DHCS in meeting its MCMC quality goals and objectives. Several of these initiatives are described below.

Medical Home and Medi-Cal Managed Care Expansion

MCMC is expanding the State's managed care delivery system geographically and by including new populations and beneficiaries. Current and future examples of efforts to expand the managed care delivery system include:

Transition of the Seniors and Persons with Disabilities Population into Managed Care

The transition of the SPD population from FFS into managed care was completed in May 2012. Transitioning the SPD population into managed care allows MCMC to achieve care coordination, better manage chronic conditions, and improve health outcomes for the SPD population.

MCMC conducted a comprehensive statewide survey of 1,521 SPDs who participated in the transition to managed care. The results were generally positive, including:

- 74 percent reported their quality of care as the same or better after the transition.
- 63 percent reported being somewhat or very satisfied with their benefits.
- 71 percent reported their ability to make appointments with a primary care doctor was about the same or easier after the transition.
- 80 percent stated their providers' understanding of how to care for persons with their specific health condition was the same or better after the transition.

Shifting the Healthy Families Program into Medi-Cal Managed Care

The Healthy Families Program (HFP) is California's version of the Children's Health Insurance Program (CHIP). DHCS began to transition HFP beneficiaries into Medi-Cal managed care on

January 1, 2013. The transition of approximately 875,000 HFP beneficiaries will be implemented in four separate phases over the course of one year. The transition of HFP beneficiaries to Medi-Cal will simplify eligibility and coverage for children and families and provide additional benefits and lower costs for children at certain income levels.

Rural Expansion

Beginning in September 2013, the Medi-Cal managed care services will expand into rural areas that are now FFS only. The expansion of managed care includes the following rural FFS counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

Performance Measures

As part of its MCP performance monitoring processes, MCMC requires the contracted MCPs to report on a select set of performance measures. In addition to reporting the required measures in 2013, full-scope MCPs were required to report a separate rate for their SPD population for the following measures:

- *Ambulatory Care—Emergency Department (ED) Visits*
- *Ambulatory Care—Outpatient Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioner (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*

- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *All-Cause Readmissions*

MCMC compared the SPD rates to the non-SPD rates for the selected measures to assess if differences in care and health status existed between the two populations. Since this was the first year MCPs were required to report the SPD rates, DHCS will conduct additional analyses after the 2014 rates are calculated.

Medical Exemptions from Managed Care Enrollment

A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into an MCP only until the Medi-Cal beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer, without deleterious medical effects, from a physician in FSS Medi-Cal to a physician of the same specialty in an MCP.

In 2012, MCMC established a MER workgroup that includes key advocates, stakeholders, and DHCS and State Legislative staff. The purpose of the MER workgroup is to revise the MER application form, draft new informing materials, create call center scripts, and participate in process and efficiency improvements.

MCMC is also undertaking a MER automation project to eliminate all manual steps that currently exist for processing MERs. The launch date for full automation occurred July 8, 2013. Although this date falls outside the review dates for this report, HSAG includes it since the information was known prior to HSAG finalizing the report.

All-Cause Readmissions Quality Improvement Project

MCPs' *All-Cause Readmissions* QIPs focus on reducing readmissions due to all causes within 30 days of an inpatient discharge among MCMC beneficiaries. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members leading to improved health outcomes. During the review period, the EQRO provided technical assistance to MCPs on conducting the barrier analyses and identifying interventions to address the barriers. MCPs began implementing MCP-specific interventions in January 2013 and established plans for periodic evaluation of each intervention.

Consumer Assessment of Healthcare Providers and Systems Survey

DHCS contracted with an EQRO to administer and report the results of the 2013 CAHPS survey that measures members' health care experience over the last six months. The survey included supplemental MCMC questions that focused on capturing the managed care experiences of the SPD population, thereby allowing for comparative analysis of beneficiary satisfaction between SPDs and the MCMC population as a whole. HSAG produced MCP- and summary-level results for both adult and children populations. MCMC and the MCPs will use the survey results to evaluate member satisfaction with the care they receive from their providers and MCPs, determine the need for further evaluation, and highlight areas where specific quality improvement interventions are needed.

Reducing Medi-Cal Smoking Rate

In line with the DHCS's Quality Strategy, by 2014, the MCMC will make available the full complement of effective tobacco-use treatments, adapt clinical systems to assess all patients for tobacco use, strongly advise those who smoke about the importance of quitting, refer smokers to evidence-based treatments, train MCP providers on evidence-based tobacco use treatment strategies, and strengthen monitoring.

Encounter Data

DHCS is engaging in the following activities to improve the quality of the MCMC encounter data:

- DHCS contracted with an EQRO to conduct an annual Encounter Data Validation (EDV) study. The goal of the study is to examine the extent to which encounter data submitted by the MCPs to MCMC are complete and accurate. During State Fiscal Year (SFY) 2012–13 (July 1 through June 30), the EDV study focused on information systems review and comparative analysis between the encounter data in the MCMC data warehouse and the data in the MCPs' data systems. For SFY 2013–14 (July 1 through June 30), the goal of the EDV study is to examine the completeness and accuracy of the encounter data the MCPs submitted to MCMC through review of medical records. Findings and recommendations for each year of the study will be presented in MCP-specific and aggregate reports. Additionally, the EQRO will produce an Encounter Data Improvement Guide to help the MCPs understand the EDV process and improve their encounter data quality.
- DHCS also has initiated an Encounter Data Improvement Project (EDIP) to strengthen encounter data for MCMC overall. The project is focused on ensuring encounter data completeness, accuracy, reasonableness, and timeliness. EDIP is improving MCP reporting of data and DHCS's process for inputting and uploading the data into the DHCS warehouse. In

the future, DHCS plans to establish compliance measurement reporting requirements for the MCPs that will measure completeness, accuracy, reasonableness, and timeliness.

DHCS is considering having its Audits & Investigations Division (A&I) include review of encounter data reporting compliance at the MCP provider level in the A&I audit process.

Compliance Standards

Section 438.358 of 42 CFR specifies that each state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP's compliance with standards established by the state related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system. DHCS conducts this review activity through an extensive monitoring process that assesses MCP compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This section covers DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

Conducting the Review

The *Medi-Cal Managed Care Program Quality Strategy Report*[13], dated June 2013, is DHCS's update to its *Medi-Cal Managed Care Program Baseline Quality Report—April 2012*. The quality strategy report describes the standards and processes DHCS uses to evaluate the operational structure and procedures MCPs use as required by the CFR. Contracts between DHCS and the MCPs include provisions for the standards, including the frequency of reporting, monitoring, and enforcement of corrective actions.

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCP compliance with contract requirements and State and federal regulations. These audits were conducted for each MCP approximately once every three years.

During the review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's A&I Division began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013),

[13] *Medi-Cal Managed Care Program Quality Strategy Report—Annual Update, June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx#qualitystrategyreports

was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[14] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual DHCS A&I medical audits, DMHC SPD enrollment surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013, for each MCP related to compliance monitoring standards within the CFR to assess performance related to the quality and timeliness of, and access to, care. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols. Additionally, HSAG used information from MCP-produced internal quality evaluations as appropriate, in conjunction with MCMC's monitoring results, to make an assessment of each MCP's compliance related to the quality and timeliness of, and access to, care provided to MCMC members.

HSAG organized, aggregated, and analyzed results from MCMC's compliance monitoring reviews to draw conclusions about overall MCP performance in providing quality, accessible, and timely health care and services to MCMC beneficiaries. Compliance monitoring standards fall primarily under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

During the review period for this report (July 1, 2012, through June 30, 2013), HSAG reviewed the progress MCMC made in ensuring a comprehensive audit is conducted at least once within a three-year period with all MCPs. HSAG also reviewed opportunities for improvement from the last reporting period and assessed if MCMC followed up with MCPs to ensure requirements were met.

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[14] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable Medi-Cal Managed Care Division All Plan and Policy Letters pertaining to the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

Objectives

The primary objective of monitoring organizational assessment and structure performance standards is to assess MCPs' compliance with federal regulations and State-specified standards.

Methodology

MCMC conducted monitoring of MCPs' compliance with federal and State-specified standards in collaboration with other State entities through a variety of activities, including:

- DMHC SPD enrollment surveys.
- DMHC routine medical surveys.
- DHCS A&I medical audits.
- DHCS member rights and program integrity monitoring reviews.

Assessment of MCP Monitoring

During the previous reporting period (July 1, 2011, through June 30, 2012), HSAG evaluated MCMC's compliance monitoring process of the MCPs against federal requirements. While HSAG had several recommendations for the MCPs, the only recommendation for MCMC was to ensure that a comprehensive audit is conducted at least once within a three-year period with all MCPs and that all federal requirements are met. A detailed statement provided by MCMC is provided in Appendix E.

Findings

As indicated above, during the reporting period, MCMC transitioned to new monitoring protocols to ensure the MCPs' progress with addressing findings and deficiencies is actively and continuously monitored until full resolution is achieved. HSAG's assessment of the compliance reports found that for MCPs with outstanding findings noted in their 2011–12 MCP-specific reports, MCMC conducted follow-up and noted that the findings were resolved during the reporting period. MCMC's review of one MCP was not conducted within three years of the review dates for this report, but this is a significant improvement from the last reporting period where eight MCPs fell outside the three-year requirement. Please note that based on the information in the MCP-specific compliance reports, HSAG cannot determine if the MCMC reviews included a comprehensive assessment of the MCPs' compliance with all federal requirements.

Compliance Standards Results

HSAG assessed the dates of each MCP's reviews to determine which were conducted within three years of the start of the review period for this report (July 1, 2012). As indicated above, one MCP had a review that fell outside the three-year time frame, meaning its review occurred prior to July 1, 2009. Below, HSAG summarizes the types of reviews conducted from July 1, 2009, through June 30, 2013, and the findings from the reviews across all MCPs.

Below are the four types of reviews conducted and the areas assessed within each type of review.

DMHC SPD Enrollment Surveys

- Availability and Accessibility
- Continuity of Care
- Member Rights
- Quality Management
- Utilization Management

DMHC Routine Medical Surveys

- Access and Availability of Services
- Access to Emergency Services and Payment
- Continuity of Care
- Grievances and Appeals
- Language Assistance
- Prescription (RX) Drug Coverage
- Quality Management
- Utilization Management

DHCS A&I Division Medical Audits

- Access and Availability
- Continuity of Care
- Member's Rights and Responsibilities
- Organization and Administration of Plan
- Quality Improvement System

- Quality Management
- State Supported Services (Abortion Services)
- Utilization Management

DHCS Medi-Cal Managed Care Member Rights and Program Integrity Monitoring Reviews

- Cultural and Linguistic Services
- Marketing
- Member Grievances
- Physical Accessibility
- Prior Authorization Notification
- Program Integrity
- SPD Sensitivity Training

Since the areas assessed through the various reviews overlap significantly, rather than provide results for each type of review, HSAG summarizes the findings across all types of reviews for all MCPs. MCPs demonstrated strengths as well as opportunities for improvement with compliance standards.

Although one MCP had multiple findings in all areas reviewed by A&I, overall, review results showed that most MCPs were compliant with most or all of the standards, and many of the findings were resolved within the review period for this report. MCPs had comprehensive quality management programs in place and the staffing and structure to support the delivery of quality, accessible, and timely health care services to MCMC beneficiaries. As was true in 2011–12, the area with the most opportunities for improvement was Access and Availability/Access and Availability of Services. The other areas with several opportunities for improvement were Member Rights/Member's Rights and Responsibilities—Under the Grievance System, Quality Management/Quality Improvement System, and Utilization Management. Below, HSAG summarizes the findings within the review areas with multiple findings across MCPs.

Access and Availability/Access and Availability of Services

- Overall, MCPs had processes to ensure MCMC beneficiaries have access to needed health care services.
- Some MCPs did not display the required provider accessibility indicator information on their websites.

- Most of the findings were related to the MCPs not having policies and procedures related to access and availability standards, including policies stating:
  - The ratio of enrollees to physicians within the MCP's provider network.
  - How the MCP would monitor waiting times in the providers' offices.
  - The MCP would ensure that misdirected emergency services claims are received by providers/claimants within the required time frame.
  - The MCP will ensure that 90 percent of all clean claims will be paid within 30 days of the date of receipt.

Member Rights/ Member's Rights and Responsibilities—Under the Grievance System

- Overall, MCPs had grievance policies and procedures in place and a grievance system for member complaints. Additionally, MCPs had policies and procedures regarding members' rights to confidentiality.
- With the exception of two MCPs lacking policies that included all requirements for processing and responding to expedited grievances, the findings in the area of Member Rights/Member's Rights and Responsibilities—Under the Grievance System did not cut across most MCPs but were individual issues for a specific MCP. Although they were individual issues, most were related to development and implementation of required policies and procedures.

Quality Management/Quality Improvement System

- As in prior years, MCPs generally performed well in the area of Quality Management/Quality Improvement System, demonstrating that MCPs have strong quality improvement programs and are monitoring the quality of care delivered to MCMC beneficiaries.
- Most of the findings were related to requirements related to the MCPs' Quality Improvement/Utilization Management Committee. Findings included:
  - Not including all required documentation in the meeting minutes.
  - Not having required specialist provider representation on the committee.

Utilization Management

- Evidence demonstrated that all MCPs implemented a utilization management program supported by policies and procedures and written criteria based on sound medical evidence.
- Most of the findings in the area of Utilization Management were due to the MCPs either lacking a policy or procedure or not following established processes.

DHCS identified very few findings across the MCPs in all other areas assessed. Of the MCPs assessed for their progress on providing SPD sensitivity training and conducting physical accessibility surveys, all but one were found to be making satisfactory progress on providing SPD

sensitivity training and all were found to be making satisfactory progress on conducting physical accessibility surveys.

Conclusions

Taking into account the findings, most of the MCPs were compliant with most of the standards, and some MCPs were compliant with all of the standards. MCPs generally had appropriate resources and written policies and procedures in place to support a quality improvement program. Additionally, MCPs generally provided evidence that the policies and procedures were implemented in accordance with the requirements.

As in prior years, most of the findings from the reviews impacted the access and timeliness domains of care. MCPs resolved most of the findings through the corrective action plan process or by providing documentation of the actions taken to resolve the findings as part of DHCS's follow-up process. Several MCPs provided documentation of actions they took to correct unresolved findings noted in their 2011–12 MCP-specific evaluation reports as part of HSAG's process for developing the 2012–13 MCP-specific evaluation reports. The areas with the most opportunity for improvement were Access and Availability/Access and Availability of Services, Member Rights/Member's Rights and Responsibilities—Under the Grievance System, Quality Management/Quality Improvement System, and Utilization Management.

Recommendations

Based on the compliance standards results, HSAG provides the following recommendations to the MCPs for improved compliance with federal and State standards:

- Address areas of noncompliance in their work plans and ensure that corrective action is taken and deficiencies are continually monitored.
- Ensure that all required provider accessibility indicator information is displayed on their websites.
- Ensure that access and availability policies and procedures are developed, implemented, and monitored.
- Ensure that grievance system policies and procedures are developed, implemented, and monitored.
- Ensure that they document all required information in the Quality Improvement/Utilization Management Committee meeting minutes.
- Ensure that they have the required specialist provider representation on the Quality Improvement/Utilization Management Committee.

Based on the compliance standards results, HSAG provides the following recommendations to MCMC regarding its oversight of the MCPs' compliance with federal and State standards:

- Continue implementation of DHCS's new monitoring protocols to ensure the MCPs' progress with addressing findings and deficiencies is actively and continuously monitored until full resolution is achieved.
- Ensure a comprehensive audit is conducted at least once within a three-year period with all MCPs.
- Compare the compliance tool used for the various DHCS reviews to the CFR to ensure all federal requirements are assessed within the three-year required time frame.

Performance Measure Validation

Validating performance measures is one of the three mandatory external quality review activities described at 42 CFR §438.358(b)(2). The requirement at §438.358(a) allows states, agents that are not an MCO or PIHP, or an EQRO to conduct the mandatory activities. Performance results can be reported to the state by the plan (as required by the state), or the state can calculate the plan's performance on the measures for the preceding 12 months. Performance must be reported by each plan—or calculated by the state—and validated annually.

In accordance with 42 CFR §438.240(b), DHCS contractually requires MCPs to have a quality program that calculates and submits performance measure data. DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to MCMC beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

As permitted by 42 CFR §438.258(a), DHCS contracted with HSAG to conduct the functions associated with validating performance measures. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

Conducting the Review

Each full-scope MCP calculated and reported MCP-specific data for the following DHCS-selected measures in the 2013 External Accountability Set:

- *All-Cause Readmissions* (DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative QIP)
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Ambulatory Care—Outpatient Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—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 (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 1*
- *Medication Management for People with Asthma—Medication Compliance 50% Total*
- *Medication Management for People with Asthma—Medication Compliance 75% Total*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Use of Imaging Studies for Low Back Pain*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Each specialty MCP calculated and reported MCP-specific data for two measures approved by DHCS. The measures varied by MCP based on the demographics of each MCP's population and are listed below.

AIDS Healthcare Foundation

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

Family Mosaic Project (non-HEDIS measures)

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

Senior Care Action Network (SCAN) Health Plan

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

Performance Measure Requirements and Targets

MCMC's quality strategy describes the program's processes to define, collect, and report MCP-specific performance data, as well as overall MCMC performance data on DHCS-required measures. MCPs must report county-level rates unless otherwise approved by DHCS.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability.

DHCS based the MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the CDC–H9 (>9.0 percent) measure. For the CDC–H9 (>9.0 percent) measure, a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

MCPs not meeting the MPLs must submit an improvement plan that outlines actions and interventions the MCP will take to achieve acceptable performance. MCMC uses the established HPLs as a performance goal and recognizes MCPs for outstanding performance.

Objectives

HSAG conducted an NCQA HEDIS Compliance Audit™[,15] (or a performance measure validation audit for non-HEDIS measures) to evaluate the accuracy of performance measure results reported by the MCPs and to ensure that the MCPs followed specifications established by MCMC.

To assess performance related to quality, access, and timeliness of care, HSAG presents the audited rates for each MCP compared to the prior year's rates and the DHCS-established MPLs/HPLs.

Methodology

To assist MCPs 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 External Accountability Set requirements for 2013 indicate that MCPs are responsible for adhering to the most current HEDIS specifications.

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 information systems (IS) capabilities assessment and an evaluation of compliance with HEDIS specifications for a plan. MCMC requires that MCPs undergo an annual compliance audit conducted by its contracted EQRO.

The HEDIS process begins well in advance of MCPs reporting their rates. Plans calculated their 2013 HEDIS rates with measurement data from January 1, 2012, to December 31, 2012. Performance measure calculation and reporting typically involves three phases: Pre-On-site, On-site, and Post-On-site.[16]

Pre-On-site Activity (October through December)

- MCPs prepare for data collection and the on-site audit.

[15] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).
[16] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Calculating Performance Measures: A Protocol for use in Conducting Medicaid External Quality Review Activities*. Final Protocol, Version 1.0. May 1, 2002.

- MCPs complete the HEDIS Record of Administration, Data Management, and Processes (Roadmap),[17] a tool used by MCPs to communicate information to the auditor about the MCPs' systems for collecting and processing data for HEDIS.

On-site Activity (January through April)

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

Post-On-site Activity (May through October)

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

Data Collection Methodology

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

Administrative Method

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

Following are the DHCS-selected External Accountability Set measures for which NCQA methodology requires using the administrative method to derive rates:

- *All-Cause Readmissions*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Ambulatory Care—Outpatient Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*

[17] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Breast Cancer Screening*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Inpatient Hospitalizations*
- *Osteoporosis Management in Women Who Had a Fracture*
- *Out-of-Home Placements*
- *Use of Imaging Studies for Low Back Pain*
- *Medication Management for People with Asthma—Medication Compliance 50% Total*
- *Medication Management for People with Asthma—Medication Compliance 75% Total*

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

Hybrid Method

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

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

In contrast, using the administrative method, if the plan finds that 4,000 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 External Accountability Set measures for which NCQA methodology allows hybrid data collection:

- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Colorectal Cancer Screening*
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

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, only two of MCMC's contracted MCPs currently report rates in this manner—Kaiser–Sacramento County and Kaiser–San Diego County. The Kaiser MCPs have information systems capabilities, primarily due to their closed-system model and electronic medical records that support

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

HSAG computed the 2013 MCMC weighted average for each measure reported by the full-scope MCPs using MCP-reported rates and weighted these by each MCP's reported eligible population size for the measure. Rates reported as "*NA*," denoting *Small Denominator,* or "*NR*" (*Not Reportable*) were not included in the calculations of these averages. This is a better estimate of care for all MCMC beneficiaries than a straight average of MCMC MCPs' performance.

Findings

Performance Measure Validation Results

All 25 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, the MCP underwent a performance measure validation audit consistent with the CMS protocol for conducting performance measure validation.[18]

Either HSAG's NCQA-certified compliance auditors or HSAG's subcontracted NCQA-certified compliance auditors performed all 25 MCP audits for the 2013 reporting year. Of the 25 audited MCPs, 22 used an NCQA-certified software vendor to produce rates. All of these software vendors achieved full certification status for the reported HEDIS measures. For the three MCPs that did not use a certified software vendor, HSAG reviewed and approved the source code. HSAG also reviewed and approved 23 MCPs' source codes, either internal or vendor-created, for the *All-Cause Readmissions* statewide collaborative QIP since this measure is not certified under software certification for Medicaid.

Conclusions

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.

[18] 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.

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

Recommendations

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

- Ensure that the rendering provider detail is included on all submitted claims and encounters, especially for services performed at multispecialty and group practices. Inclusion of the rendering provider is important for measures that require a specific provider specialty, such as:
  - The identification of a primary care provider for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Weight Assessment and Counseling for Nutrition and Physical Activity*; and *Children and Adolescent's Access to Primary Care Practitioners*.
  - The identification of a nephrologist, optometrist, and ophthalmologist for the *Comprehensive Diabetes Care* measures.

  Improving capture of the rendering provider can decrease the burden of medical record review for measures that allow for hybrid reporting.
- Explore the use of supplemental data with greater coordination and oversight to enhance HEDIS reporting. More stringent requirements will be fully enforced for HEDIS 2014, which could invalidate a database if not properly validated by the MCP.
- Closely monitor timelines, milestones, and deliverables of contracted providers and certified software vendors. MCPs should consider implementing sanctions for vendors that do not meet contractual requirements.
- Work to increase electronic data submission from providers.
- Improve reporting accountability by clearly documenting the data audit process.

Performance Measure Results for Full-Scope Managed Care Plans

Using the validated performance measure rates, HSAG organized, aggregated, and analyzed the data to draw conclusions about full-scope MCP performance in providing accessible, timely, and quality care and services to MCMC beneficiaries.

Table 5.1 lists the DHCS-required performance measures for full-scope MCPs in 2013 and the abbreviations used for each measure in Table 5.2.

Table 5.1—Name Key for Performance Measures in External Accountability Set for Full-Scope Managed Care Plans

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions*‡
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
CBP	*Controlling High Blood Pressure*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MMA–75	*Medication Management for People with Asthma—Medication Compliance 75% Total*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.

‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative QIP.

Table 5.2 presents a summary of the MCMC HEDIS 2013 (based on calendar year 2012 data) performance measure weighted averages compared to MCMC HEDIS 2012 (based on calendar year 2011 data). MCP-specific rates for each measure are included in Appendix A.

For all but one measure, MCMC bases its MPLs and HPLs on NCQA's national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—a low rate indicates better performance and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the Medicaid 10th percentile.

Table 5.2—2012–13 Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results for Full-Scope Managed Care Plans

Performance Measure[1]	Domain of Care[2]	2012 HEDIS Rates[3]	2013 HEDIS Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	25.32%	29.96%	★★	↑	18.98%	33.33%
ACR	Q, A	--	14.43%	--	Not Comparable	--	--
AMB–ED	‡	39.64	43.15	‡	Not Comparable	‡	‡
AMB–OP	‡	273.09	283.14	‡	Not Comparable	‡	‡
CAP–1224	A	95.74%	94.42%	★	↓	95.56%	98.39%
CAP–256	A	87.13%	84.89%	★	↓	86.62%	92.63%
CAP–711	A	86.88%	85.89%	★	↓	87.56%	94.51%
CAP–1219	A	85.82%	85.62%	★	↓	86.04%	93.01%
CBP	Q	--	58.30%	--	Not Comparable	--	--
CCS	Q,A	69.70%	65.11%	★★	↓	61.81%	78.51%
CDC–BP	Q	67.49%	63.20%	★★	↓	54.48%	75.44%
CDC–E	Q,A	55.52%	51.32%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	50.79%	49.35%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	38.04%	40.35%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	84.20%	83.19%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	40.51%	38.27%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	79.44%	78.54%	★★	↔	70.34%	83.45%
CDC–N	Q,A	81.90%	81.80%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	78.15%	77.25%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	62.99%	72.66%	★★	↑	50.36%	80.91%
LBP	Q	81.03%	80.84%	★★	↔	72.04%	82.04%
MMA–50	Q	--	58.85%	--	Not Comparable	--	--
MMA–75	Q	--	36.52%	--	Not Comparable	--	--
MPM–ACE	Q	81.49%	80.77%	★	↓	83.72%	91.33%
MPM–DIG	Q	86.44%	86.91%	★	↔	87.93%	95.56%
MPM–DIU	Q	80.44%	80.54%	★	↔	83.19%	91.30%

Performance Measure[1]	Domain of Care[2]	2012 HEDIS Rates[3]	2013 HEDIS Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
PPC–Pre	Q,A,T	83.77%	83.17%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	61.74%	58.61%	★	↓	58.70%	74.73%
W-34	Q,A,T	76.77%	74.50%	★★	↔	65.51%	83.04%
WCC–BMI	Q	68.33%	71.55%	★★	↑	29.20%	77.13%
WCC–N	Q	72.08%	72.53%	★★	↔	42.82%	77.61%
WCC–PA	Q	56.04%	58.28%	★★	↔	31.63%	64.87%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] Performance comparisons are based on comparing the 95-percent confidence levels associated with 2012 and 2013 rates.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.

Seniors and Persons with Disabilities Performance Measure Stratification

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[19] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began in June 2011 and was completed by June 2012.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in some measures, such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures which could reflect possible access issues that could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Appendix B includes the SPD and non-SPD rates for each MCP, with an MCP-specific comparison of the SPD and non-SPD rates and the total combined MCP-specific rate for all measures except for the *Ambulatory Care* measures.[20]

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*

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[19] Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care plan and for the subset of enrollees who are Seniors and Persons with Disabilities. Managed care plan performance measures may include HEDIS measures; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

[20] The Ambulatory Care measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however, rates should be interpreted 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.

- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Full-Scope Managed Care Plan Performance Measure Result Findings

MCMC's 2013 results were similar to reporting years 2011 and 2012 in that the majority of the rates were between the MPLs and HPLs. Strengths and areas that need improvement are described below.

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

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

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

Conversely, the MCMC weighted averages for the following measures were below the MPLs in 2013, which is the first year the weighted averages for these measures were below the MPLs:

- All three *Annual Monitoring for Patients on Persistent Medications* measures.
- All four *Children and Adolescents' Access to Primary Care Practitioners* measures.
- *Prenatal and Postpartum Care—Postpartum Care.*

The MCMC weighted average rate for the *Prenatal and Postpartum Care—Postpartum Care* measure declined significantly from 2012 to 2013, which is what led to the rate moving from above the MPL in 2012 to below the MPL in 2013. Although the MCMC weighted average rate for the *Annual Monitoring for Patients on Persistent Medications—ACE* measure declined significantly from 2012 to 2013, HSAG cannot accurately assess if the statistically significant decline in the rate for this measure is what led to the rate being below the MPL in 2013, because 2013 was the first year the MCPs were held to the MPL for this measure.

MCMC had three measures with statistically significant improvement in weighted average rates from 2012 to 2013 compared to seven measures from 2011 to 2012. In addition to the significant decline in rates for the *Prenatal and Postpartum Care—Postpartum Care* and *Annual Monitoring for Patients on Persistent Medications—ACE* measures, the MCMC weighted average rates for two other quality measures, *Cervical Cancer Screening* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, declined significantly from 2012 to 2013. The performance comparison results show that overall, MCMC had fewer measures with significant improvement in 2013 when compared to 2012 and more measures with weighted average rates that declined significantly in 2013 when compared to 2012.

High and Low Plan Performers

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

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

Model Type Performance

As in previous years, the COHS model type outperformed the GMC and TPM types, with better rates on 24 of the 30 performance measures (*Ambulatory Care—Outpatient Visits* and *Ambulatory Care—ED Visits* were not considered because they are utilization measures, and *All-Cause Readmissions* was included in this comparison). The TPM outperformed the other model types for three measures, and the GMC model type outperformed the other model types on the remaining three measures.

Because the COHS model type is the only option for MCMC 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.

HEDIS Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

Please note that DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures with rates below the MPLs for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact. Additionally, MCPs with *Cervical Cancer Screening* rates below the MPLs in 2013 will not be required to submit an IP for this measure. In August 2013, it was learned that significant changes were made to the specifications for the *Cervical Cancer Screening* measure. NCQA will therefore not publically report this measure for HEDIS 2014, and DHCS made a decision that the MCPs with *Cervical Cancer Screening* rates below the MPLs in 2013 would not be required to submit an IP for the measure. Finally, in March 2014, DHCS made a decision that MCPs with *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* and *Comprehensive Diabetes Care—LDL-C Screening* rates below the MPLs in 2013 will not be required to submit an IP for either measure, and MCPs using these measures as QIP indicators will not be required to report on the indicators in 2013 or beyond. This decision was made based on new cholesterol management guidelines being released[21] and the potential for these measures being eliminated by NCQA beginning in reporting year 2015. Although the decisions were made after the review period for this report, HSAG includes them in this report since they were made prior to the report being finalized.

[21] Stone NJ, Robinson J, Lichtenstein AH, et al. 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. 2013. Available at: http://www.cardiosource.org/science-and-quality/journal-scan/2013/11/2013-acc-aha-guideline-on-the-treatment-of-blood-cholesterol.aspx.

HEDIS Improvement Plans Findings

Most MCPs' IPs with rates below the MPLs were successful at improving the rates to above the MPLs in 2013; however, one MCP, Anthem Blue Cross Partnership Plan, had seven IPs in place encompassing multiple counties during the review period, and none of them were successful at improving the measures' rates to above the MPLs. DHCS is working with the MCP, which has a corrective action plan in place, to identify improvement strategies for improving performance.

HSAG reviewed the MCPs' IPs and found that, unlike in previous years, most MCPs conducted new barrier analyses and identified new interventions for existing IPs. Additionally, most MCPs used data to drive their IPs and identified achievable outcomes. The MCPs' improvements in IP development are likely a result of MCMC implementing a more rigorous IP review and approval process and requiring MCPs to develop IPs driven by data analyses and identify interventions to address the priority barriers.

Seniors and Persons with Disabilities Result Findings

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

Specialty Managed Care Plan Performance Measure Result Findings

AIDS Healthcare Foundation

AIDS Healthcare Foundation reported rates for the *Controlling High Blood Pressure* and *Colorectal Cancer Screening* measures. The rates for both measures were above the MPLs in 2013.

Family Mosaic Project (non-HEDIS measures)

Family Mosaic Project (FMP) reported on two non-HEDIS measures:

- *Inpatient Hospitalizations*: The percentage of Medi-Cal managed care members enrolled in Family Mosaic who have a mental health admission to an inpatient hospital facility during the measurement period.

- *Out-of-Home Placements*: The percentage of Medi-Cal managed care members enrolled in Family Mosaic who are discharged to an out-of-home placement during the measurement period.

For the *Inpatient Hospitalizations* measure, the rates for two and three admissions reached the maximum performance level, with both rates at 0.0 percent. The rate for one admission was at 2.9 percent. Based on FMP's strong performance on the *Inpatient Hospitalizations* measure, the MCP was directed to stop reporting on this measure starting in 2014 and identify a new measure to report for its Medi-Cal population.

The rate for the *Out-of-Home Placements* measure dropped from 6.3 percent in 2012 to 4.1 percent in 2013. Although the decrease was not statistically significant, the change in the rate reflected an improvement in performance.

Senior Care Action Network Health Plan

Senior Care Action Network Health Plan reported rates for the *Breast Cancer Screening* and *Osteoporosis Management in Women Who Had a Fracture* measures. The rate for the *Breast Cancer Screening* measure was above the HPL for the second consecutive year. Although the rate for the *Osteoporosis Management in Women Who Had a Fracture* measure was 1.3 percentage points lower than the 2012 rate, the 2013 rate remained above the MPL.

Conclusions

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

DHCS continued a variety of mechanisms that support the improvement efforts of MCPs. The auto-assignment program offers an increased incentive for MCPs in the GMC model and TPM types to perform well by rewarding higher-performing MCPs with increased default membership. During 2012, DHCS met with its contracted MCPs to obtain input on potential measure changes to the 2013 EAS, including changes that may impact auto-assignment. DHCS may make modifications to the auto-assignment measures in 2014 to continue to emphasize improved performance across the measure set. Additionally, DHCS has supported MCPs in selecting performance measures for formal QIPs to help structure improvement efforts to increase the likelihood of achieving statistically significant and sustained improvement. DHCS has taken a more active role in reviewing the MCPs' QIP proposals to ensure that MCPs are selecting areas that are actionable and need improvement rather than selecting topics of consistent or high performance. DHCS evaluates its External Accountability Set and auto-assignment program measures annually to rotate out measures that show consistent, high performance among MCPs.

For the 2013 External Accountability Set, DHCS retired the *Adolescent Well-Care Visits (AWC)* measure to focus on three new measures. This process allows DHCS to identify and select new measures as opportunities for improvement. Finally, DHCS has improved its oversight process of the MCPs' performance over time and has begun to work with MCPs that have demonstrated poor performance over several years on multiple measures.

Recommendations

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

- MCPs need to place a greater emphasis on efforts that are data-driven and can actually improve health outcomes rather than approaching development of HEDIS improvement plans as an exercise in documentation.
- MCPs should select performance measures with poor rates as the focus for formal QIPs in order to achieve acceptable performance for all measures and implement rapid cycle quality improvement methods.
- MCPs need to identify barriers based on available data and link improvement strategies to the barriers having the greatest negative effect on the targeted HEDIS rate.
- MCPs should evaluate the SPD and non-SPD populations during their barrier analyses and develop targeted interventions when appropriate.
- MCPs need to consider evidence-based strategies when selecting interventions.
- MCPs need to track and monitor interventions and critically evaluate intervention effectiveness to identify those interventions that have been successful, those that should be modified, and those that should be discontinued.
- MCPs should consider working with MCMC and the EQRO as a source of more intensive technical assistance for measures that continue to demonstrate low performance over consecutive years.

Based on the review of the 2013 HEDIS results, HSAG provides the following recommendations to MCMC regarding its oversight of the MCPs' performance on External Accountability Set measures:

- 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.

- Engage in the following efforts related to IPs:
  - Continue to thoroughly assess IPs submitted by the MCPs to ensure thorough barrier analyses have been completed and that the identified interventions address the prioritized barriers.
  - Continue to assess if development of an IP is needed when an MCP has a QIP related to a performance measure with a rate below the MPL, and consider conducting quarterly monitoring, at minimum, of the MCP's QIP to assess if progress is being made on moving the rate above the MPL.
  - Monitor, at least quarterly, the MCPs' progress on implementing IPs to ensure the MCPs are engaging in rapid cycle improvement methods to improve performance on the measures.
- Identify State-level barriers and develop strategies for addressing the barriers.

Quality Improvement Projects

Validating performance improvement projects is one of the three mandatory external quality review activities described at 42 CFR §438.358(b)(1). The requirement allows states, agents that are not an MCO or PIHP, or an EQRO to conduct the mandatory activity.

In accordance with 42 CFR §438.240(d), DHCS contractually requires MCPs to have a quality program that (1) includes an ongoing program of QIPs designed to have a favorable effect on health outcomes and enrollee satisfaction, and (2) focuses on clinical and/or nonclinical areas that involve the following:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve improvement in quality.
- Evaluating the effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

DHCS contracted with HSAG to conduct the functions associated with the validation of QIPs.

Conducting the Review

The purpose of a QIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[22] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported results as well as in improvements that may have contributed to the results.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county. Specialty MCPs must conduct a minimum of two QIPs; however, because specialty MCPs serve unique populations that are limited in size, DHCS does not require specialty MCPs to participate in the statewide collaborative QIP.

[22] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): 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.

Instead, specialty MCPs are required to design and maintain two internal QIPs with the goal to improve health care quality, access, and/or timeliness for the specialty MCPs' MCMC members.

MCPs submit QIP topic proposals to DHCS for review and approval. DHCS reviews each QIP topic to determine its relevance to the MCMC population; whether the topic addresses a key performance gap; and whether the project has the ability to improve member health, functional status, or satisfaction. Once DHCS approves the QIP topic, the MCP submits the QIP study design to HSAG for validation.

MCPs perform data collection and analysis for baseline and remeasurement periods and report results to DHCS and to HSAG for QIP validation at least annually. Once a QIP is complete, the MCP must submit a new topic proposal to DHCS within 90 days to remain compliant with having two QIPs under way at all times.

Quality Improvement Project Requirements and Targets

DHCS requires that QIPs achieve an overall *Met* validation status, which demonstrates compliance with CMS's protocol for conducting QIPs.[23] If a QIP achieves an overall *Partially Met* or *Not Met* validation status, the MCP must address the areas of noncompliance and resubmit the QIP.

Objectives

The purpose of a QIP is to achieve through ongoing measurements and interventions statistically significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvement in care and for interested parties to have confidence in the reported results, the QIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time frame.

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, it is more likely that member health, functional status, and/or satisfaction will be positively affected.

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[23] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 7: Implementation of Performance Improvement Projects: A Voluntary 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.

HSAG organized, aggregated, and analyzed MCPs' validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

Methods

HSAG reviewed and assessed MCP compliance with the following 10 CMS activities:

- Activity I. Appropriate Study Topic.
- Activity II. Clearly Defined, Answerable Study Question(s).
- Activity III. Clearly Defined Study Indicator(s).
- Activity IV. Correctly Identified Study Population.
- Activity V. Valid Sampling Methods (if sampling was used).
- Activity VI. Accurate/Complete Data Collection.
- Activity VII. Sufficient Data Analysis and Interpretation.
- Activity VIII. Appropriate Improvement Strategies.
- Activity IX. Real Improvement Achieved.
- Activity X. Sustained Improvement Achieved.

Each required protocol activity consists of evaluation elements necessary to complete a valid QIP. HSAG's QIP Review Team scored the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, or *Not Applicable (NA)*.

To ensure a sound and effective review, HSAG designates some of the elements as critical elements. All of the critical elements must be *Met* for the QIP to produce valid and reliable results. The scoring methodology also includes a *Not Applicable* designation for situations in which the evaluation element does not apply to the QIP and a *Not Assessed* scoring designation when the QIP has not progressed to certain activities in the CMS protocol.

Findings

HSAG first presents QIP validation findings related to the overall study design and structure to support a valid and reliable QIP and then presents QIP outcomes achieved during the review period of July 1, 2012, through June 30, 2013. MCP-specific evaluation reports released in tandem with the technical report provide detailed analysis of QIP validation and project outcomes at the MCP level. See Appendix C for the MCP-specific QIP information, including validation results, assignment of domain(s) of care, and intervention and outcome information (as applicable).

Quality Improvement Project Validation Findings

One statewide collaborative QIP was in progress during the review period—the *All-Cause Readmissions* statewide collaborative QIP. The *All-Cause Readmissions* QIP was in the study design phase. The *All-Cause Readmissions* QIP study design submissions and the MCP-initiated internal QIPs were scored according to the approved protocol. Each submitted QIP had to achieve a *Met* validation status. If the QIP did not achieve a *Met* validation status, then the MCP resubmitted the QIP until a *Met* validation status was achieved.

Table 6.1 summarizes the validation results for all statewide collaborative QIP submissions and MCP-internal QIP submissions across CMS protocol activities during the review period. Results are averaged across submissions and resubmissions. Please note that all QIPs were assessed for Activities I through VI, but not all QIPs were assessed for Activities VII through X because they did not progress to the Implementation and Outcomes stages.

Table 6.1—QIP Validation Results from July 1, 2012, through June 30, 2013*
(Number = 133 QIP Submissions from 25 Plans)

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	98%	2%	0%
	II: Clearly Defined, Answerable Study Question(s)	97%	3%	0%
	III: Clearly Defined Study Indicator(s)	94%	6%	0%
	IV: Correctly Identified Study Population	91%	9%	0%
	V: Valid Sampling Techniques (if sampling is used)	93%	1%	6%
	VI: Accurate/Complete Data Collection	78%	9%	13%
Design Total**		**89%**	**6%**	**6%**
Implementation	VII: Sufficient Data Analysis and Interpretation	87%	8%	5%
	VIII: Appropriate Improvement Strategies**	84%	10%	5%
Implementation Total		**86%**	**9%**	**5%**
Outcomes	IX: Real Improvement Achieved	54%	10%	36%
	X: Sustained Improvement Achieved**	67%	17%	17%
Outcomes Total		**55%**	**10%**	**35%**
Overall QIP Results		**85%**	**7%**	**8%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity across all submissions and resubmissions for each QIP.

**The stage and/or activity totals may not equal 100 percent due to rounding.

MCPs demonstrated strong application of the Design stage, meeting 89 percent of the requirements for all applicable evaluation elements for this stage. The MCPs demonstrated excellent application of Activities I through V, including selecting appropriate study topics, clearly defining their study questions and study indicators, correctly identifying their study populations, and using valid sampling techniques. The activity with the greatest opportunity for improvement was Activity VI. The MCPs collectively only met 78 percent of the requirements for all applicable evaluation elements for this activity because some MCPs did not provide a complete and accurate data analysis plan and or manual data collection tools that would ensure consistent and accurate data collection.

Overall, the MCPs demonstrated strong application of the Implementation stage, meeting 86 percent of the requirements for all applicable evaluation elements for this stage. Some MCPs did not provide a complete and/or accurate interpretation of the QIP findings, and others failed to accurately identify a statistical difference between measurement periods, resulting in some lower scores for Activity VII. Also, some MCPs did not properly document the relationship between their intervention strategies and the causal barrier analysis and results, and some interventions did not appear likely to induce permanent change, resulting in lower scores for Activity VIII.

Activity IX assesses if statistically significant improvement (i.e., real improvement) over baseline is achieved, reflecting a positive effect on the members' care. During the review period, of the 22 QIPs that could be assessed for improvement, only three QIPs achieved statistically significant improvement over baseline. All of the QIPs were internal QIPs since the *All-Cause Readmissions* QIP had not yet reached this stage. Many QIP interventions were not associated with real improvement, and the QIPs lacked the critical analysis necessary to determine the effectiveness of the interventions. Without a method to evaluate the effectiveness of interventions, the MCPs are severely limited in their ability to determine if they should revise, standardize, or discontinue improvement strategies.

Activity X assesses if sustained improvement was achieved. Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Of the 15 QIPs that achieved statistically significant improvement over baseline, 12 were assessed for sustained improvement. Of the 12 assessed for sustained improvement, 10 achieved sustained improvement for at least one study indicator, and 2 did not achieve sustained improvement. Overall, the QIPs are leading to some improved health outcomes for the MCPs' members.

In prior EQR technical reports, HSAG provided a comparison of the percentage of applicable evaluation elements as *Met* for each study stage between the current reporting period and the previous reporting periods. Since the validation methodology changed in the current reporting period, a comparison cannot be made between this year's results and prior years' results. When assessing the current reporting period's overall validation results, HSAG found them to be similar

to prior years' results in that MCPs show strong application of the Design and Implementation stages, and the greatest opportunities for improvement are in the Outcomes stage.

The increased emphasis on outcomes will likely result in improved QIP outcomes over time as MCPs implement regular causal/barrier analyses, ensure that interventions address the high-priority barriers, and ensure that they have an evaluation plan for each QIP intervention. Additionally, as part of the changes to the QIP scoring methodology, HSAG implemented more effective MCP-specific improvement strategies in collaboration with DHCS, including conducting a critical analysis of MCPs' improvement strategies during the QIP validation process and providing expanded feedback to the MCPs as part of the QIP validation process.

As a way to assist MCPs with having successful QIP outcomes for the *All-Cause Readmissions* QIP, HSAG provided one-on-one technical assistance calls with each MCP rather than limiting feedback to the annual QIP submissions. The calls focused on how to conduct the causal/barrier analysis and identify interventions to address the priority barriers. Additionally, HSAG and MCMC facilitated quarterly technical assistance calls with all MCPs to discuss priority topics related to the *All-Cause Readmissions* QIP. MCMC and HSAG evaluated the MCPs' barrier analyses and interventions and provided feedback to MCPs at the study design phase to increase the likelihood that improvement strategies will be effective. Quarterly technical assistance calls will continue and one-on-one technical assistance calls will be scheduled as needed for the *All-Cause Readmissions* QIP and the MCPs' internal QIPs.

Quality Improvement Project Outcomes Findings

HSAG organized, aggregated, and analyzed QIP outcome data to draw conclusions about MCMC MCP performance in providing quality, accessible, and timely care and services to MCMC beneficiaries.

Internal Quality Improvement Projects

During the review period of July 1, 2012, through June 30, 2013, 22 internal QIPs could be assessed for statistically significant improvement over baseline, and 12 could be assessed for sustained improvement. Three of the QIPs demonstrated statistically significant improvement over the baseline period, and 10 QIPs achieved sustained improvement, meaning that the statistically significant improvement in performance achieved over baseline was maintained or increased in the current measurement period.

Table 6.2 displays the QIPs assessed for project outcomes during the review period by MCP, QIP name, and whether the outcomes demonstrated statistically significant improvement and/or sustained improvement. Please note that in cases where sustained improvement was assessed, the statistically significant improvement over baseline was achieved in a previous measurement period.

Table 6.2—Internal Quality Improvement Projects Assessed for Project Outcomes from July 1, 2012, through June 30, 2013

Plan Name	QIP Name	Statistically Significant Improvement[1]	Sustained Improvement[2]
AIDS Healthcare Foundation	*Advance Care Directives*	Yes	Not Assessed
AIDS Healthcare Foundation	*CD4 and Viral Load Testing*	No	Not Assessed
Anthem Blue Cross Partnership Plan—Alameda County	*Improving HEDIS Postpartum Care Rates*	Yes	Yes
Anthem Blue Cross Partnership Plan—Contra Costa County	*Improving HEDIS Postpartum Care Rates*	Yes	Yes
Anthem Blue Cross Partnership Plan—Sacramento County	*Improving HEDIS Postpartum Care Rates*	No	Not Assessed
Anthem Blue Cross Partnership Plan—San Francisco County	*Improving HEDIS Postpartum Care Rates*	No	Not Assessed
Anthem Blue Cross Partnership Plan—San Joaquin County	*Improving HEDIS Postpartum Care Rates*	No	Not Assessed
Anthem Blue Cross Partnership Plan—Santa Clara County	*Improving HEDIS Postpartum Care Rates*	Yes	No
Anthem Blue Cross Partnership Plan—Stanislaus County	*Improving HEDIS Postpartum Care Rates*	No	Not Assessed
Anthem Blue Cross Partnership Plan—Tulare County	*Improving HEDIS Postpartum Care Rates*	Yes	No
CalOptima	*Improving the Rates of Cervical Cancer Screening*	Yes	Yes
Care1st	*Comprehensive Diabetic Care*	No	Not Assessed
CenCal Health—San Luis Obispo County	*Weight Assessment and Counseling for Nutrition and Physical Activity*	Yes	Yes
CenCal Health—Santa Barbara County	*Weight Assessment and Counseling for Nutrition and Physical Activity*	Yes	Yes
Community Health Group Partnership Plan	*Increasing Screening for Postpartum Depression*	Yes	Yes
Community Health Group Partnership Plan	*Increasing Assessment, Diagnosis, and Appropriate Treatment of Chronic Obstructive Pulmonary Disease (COPD)*	Yes	Yes
Contra Costa Health Plan	*Reducing Childhood Obesity*	Yes	Yes
Family Mosaic Project	*Increase the Rate of School Attendance*	Yes	Not Assessed
Family Mosaic Project	*Reduction of Out-of-Home Placement*	No	Not Assessed
Health Net Community Solutions, Inc.—Kern County	*Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities (SPD)*	No	Not Assessed
Health Net Community Solutions, Inc.—Los Angeles County	*Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities (SPD)*	No	Not Assessed

Plan Name	QIP Name	Statistically Significant Improvement[1]	Sustained Improvement[2]
Health Net Community Solutions, Inc.—Sacramento County	*Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities (SPD)*	No	Not Assessed
Health Net Community Solutions, Inc.—San Diego County	*Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities (SPD)*	No	Not Assessed
Health Net Community Solutions, Inc.—Stanislaus County	*Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities (SPD)*	No	Not Assessed
Health Plan of San Joaquin	*Improving the Percentage of HbA1c Testing*	No	Not Assessed
Health Plan of San Mateo	*Increasing Timeliness of Prenatal Care*	No	Not Assessed
Inland Empire Health Plan	*Attention Deficit Hyperactivity Disorder (ADHD) Management*	No	Not Assessed
Kaiser–Sacramento County	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*	Yes	Yes
L.A. Care Health Plan	*Improving HbA1c and Retinal Eye Exam Screening Rates*	No	Not Assessed
Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino counties	*Improving Hypertension Control*	No	Not Assessed
Molina Healthcare of California Partner Plan, Inc.—Sacramento County	*Improving Hypertension Control*	No	Not Assessed
Molina Healthcare of California Partner Plan, Inc.—San Diego County	*Improving Hypertension Control*	No	Not Assessed
Partnership HealthPlan of California—Napa/Solano/Yolo	*Improving Care and Reducing Acute Readmissions for People with COPD*	Yes	Yes
Senior Care Action Network Health Plan	*Care for Older Adults*	Yes	Not Assessed

[1] Statistically significant improvement is defined as improvement over the baseline (p value < 0.05).

[2] Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

Yes = (1) Statistically significant improvement over the baseline period was noted for at least one of the QIP study indicators, or (2) sustained improvement was achieved for at least one of the study indicators.

No = (1) None of the indicators had a statistically significant improvement over the baseline period, or (2) sustained improvement was not achieved for any of the study indicators.

Not assessed = The QIP was not able to be assessed for sustained improvement because (1) the QIP had not yet achieved statistically significant improvement over the baseline period for at least one of the QIP study indicators, or (2) the current measurement period is the first measurement period where statistically significant improvement over the baseline period was achieved.

Successful QIPs affected the health of the MCMC beneficiaries in the following areas:

Advance Care Planning

- AIDS Healthcare Foundation—The MCP demonstrated statistically significant improvement in increasing the percentage of eligible members with evidence of advance care planning or having a discussion regarding advance care planning with their provider. The QIP will be assessed for sustained improvement in the next reporting period.

Care for Older Adults

- Senior Care Action Network Health Plan—The MCP demonstrated statistically significant improvement in improving the care it provides its beneficiaries by providing more functional status assessments and pain screenings. The QIP will be assessed for sustained improvement in the next reporting period.

Childhood Obesity

- CenCal Health—As in previous years, both San Luis Obispo and Santa Barbara counties demonstrated statistically significant improvement in body mass index (BMI) assessment and documentation of referrals for nutrition and physical activity counseling during the course of the projects. Additionally, the improvement has been sustained in both San Luis Obispo and Santa Barbara counties. With a more complete assessment and an improved referral process related to obesity, CenCal Health has a better understanding of the obesity issues for members aged 3 to 17 years.
- Contra Costa Health Plan—As in previous years, the MCP demonstrated statistically significant improvement in providing documentation of counseling for nutrition and physical activity during the course of the project and was able to sustain the improvement. With increased counseling for nutrition and physical activity related to obesity, the MCP has an opportunity to begin to address the obesity issues for members aged 3 to 11 years.
- Kaiser–Sacramento County—As in previous years, the MCP continued to sustain the increase in BMI assessments and improve the referral/counseling process related to obesity, thereby achieving a better understanding of the obesity issues for its members aged 3 to 17 years.

Chronic Obstructive Pulmonary Disease Assessment, Diagnosis, and Treatment

- Community Health Group Partnership Plan—As in previous years, the MCP continued to significantly improve care for members with chronic obstructive pulmonary disease (COPD) by increasing spirometry testing, decreasing emergency room visits, and decreasing inpatient discharges over the course of the project. The MCP also demonstrated sustained improvement for this QIP.

- Partnership HealthPlan of California—The MCP continued to improve the quality of care delivered to members with COPD. The MCP increased the use of spirometry testing to diagnose and classify severity stage in newly diagnosed COPD members aged 42 years and older. For members aged 40 years and older with a COPD exacerbation that resulted in an inpatient admission or an emergency room visit, the MCP improved the medication management of these members by appropriately dispensing systemic corticosteroids and bronchodilators. Additionally, the MCP documented a reduction in the readmissions of members with COPD and sustained this improvement over multiple measurement periods.

School Attendance

- Family Mosaic Project—The MCP demonstrated statistically significant reduction in the percentage of school attendance problems for the eligible members. The QIP will be assessed for sustained improvement in the next reporting period.

Women's Health

- Anthem Blue Cross Partnership Plan—The MCP increased the percentage of appropriately timed postpartum visits for women in Alameda, Contra Costa, Santa Clara, and Tulare counties; however, the MCP was only able to sustain this improvement in Alameda and Contra Costa counties. Additionally, the rate for the study indicator remained below the MPL in seven of the eight counties included in the QIP—Alameda, Contra Costa, Sacramento, San Joaquin, Santa Clara, Stanislaus, and Tulare counties. Only the rate in San Francisco County was above the MPL in 2013.
- CalOptima—The MCP continued to significantly increase the percentage of women who received a Pap test from the top 200 high-volume providers. This improvement has been sustained over multiple measurement periods.
- Community Health Group Partnership Plan—As in previous years, the MCP increased depression screening and the use of a depression screening tool at the time of a member's postpartum visit. Additionally, the MCP increased the percentage of women who received follow-up care after a positive depression screen. This improvement has been sustained over multiple measurement periods.

Conclusions

The MCPs demonstrated excellent application of Activities I through V of the Design stage, including selecting appropriate study topics, clearly defining their study questions and study indicators, correctly identifying their study populations, and using valid sampling techniques.

Although the MCPs received lower scores for the Implementation stage, the validation results show that the MCPs demonstrate a strong application of this stage. Most MCPs provided sufficient data analysis and identified appropriate improvement strategies. Some of the MCPs

implemented improvement strategies that resulted in positive outcomes, including targeted case management, pay-for-performance strategies, and use of quality improvement tools throughout the QIP process.

During the reporting period, only 3 of the 22 QIPs that could be assessed for statistically significant improvement achieved statistically significant improvement over baseline. Of the 12 QIPs that could be assessed for sustained improvement, 10 achieved sustained improvement, meaning that the statistically significant improvement in performance achieved over baseline was maintained or increased in the current measurement period. MCMC, the MCPs, and HSAG had focused discussions on conducting regular causal/barrier analyses, identifying appropriate improvement strategies, and effectively evaluating each intervention. The technical assistance provided by HSAG through the focused discussions and the ongoing technical assistance provided by MCMC should increase the likelihood of improved QIP outcomes over time.

Overall, MCPs provided the required QIP documentation; however, some MCPs needed to resubmit their QIPs multiple times because they repeatedly did not provide the required information. The MCPs have the opportunity to improve the thoroughness and accuracy of the QIP documentation and to review and respond to all feedback from HSAG in the QIP Validation Tool so the MCPs can meet all QIP documentation requirements.

Recommendations

Based on the review of the QIP validation and outcome results, HSAG provides the following recommendations to the MCPs for improving performance:

- Review the QIP Completion Instructions to ensure that all required documentation is included in the QIP Summary Form to avoid having to resubmit their QIPs.
- Ensure that they conduct routine causal/barrier analysis and include the documentation when submitting the QIP for validation.
- Evaluate each QIP intervention and document the results of the evaluation in the QIP Summary Form. Additionally, document how the evaluation results impacted the interventions (i.e., identify which were successful, which needed to be modified, and which should be discontinued).
- Implement rapid cycle improvement strategies to increase the likelihood that statistically significant and sustained improvement will be achieved. MCPs should:
    - Ensure all relevant barriers are identified.
    - Ensure that interventions are directly linked to the high-priority barriers.
    - Assess interim outcomes quarterly, at minimum, to determine if interventions should be revised, standardized, scaled up, or discontinued.

Additionally, MCPs should ensure that QIP topics address areas in need of improvement (e.g., a performance measure with a rate below the MPL, an area receiving low satisfaction ratings).

Based on the review of the QIP validation and outcome results, HSAG provides the following recommendations to MCMC regarding its oversight of the MCPs' performance on QIPs:

- Continue to assess the appropriateness of MCPs' proposed QIP topics to ensure their relevance to the MCMC population; that the topics address areas in need of improvement; and that the projects have the ability to improve member health, functional status, or satisfaction.
- Continue to provide technical assistance to the MCPs, in collaboration with the EQRO, to support the MCPs in designing valid QIPs and increasing the likelihood of statistically significant and sustained improvement.
- For MCPs that have QIP topics related to performance measures with rates below the MPLs, consider conducting quarterly monitoring, at minimum, of the MCPs' QIPs to assess if progress is being made on moving the rates above the MPLs.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the CAHPS survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of the MCMC beneficiaries as part of its process for evaluating the quality of health care services provided by MCPs to MCMC beneficiaries.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013 for all full-scope MCPs. DHCS required that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child members. HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with the HEDIS supplemental item set, to members of all 22 full-scope MCPs, which resulted in 44 distinct reporting units.[24] Specialty MCPs were not included in the CAHPS survey administration. Specialty MCPs are required to administer their own annual consumer satisfaction survey to evaluate their Medi-Cal members' satisfaction regarding care and services provided by the MCPs.

In this section of the report, HSAG first presents the MCMC CAHPS 2013 findings and then provides a summary of each specialty MCP's member satisfaction survey results. The individual full-scope MCP CAHPS results can be found in Appendix D.

CAHPS Survey Findings

The results presented are from adult members and parents or caretakers of child members who completed surveys from February to May 2013, which represent members' experiences with care and services over the prior six months. Results include members' global ratings in four areas: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. Additionally, the results of five composite measures reflect members' experiences with *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*. The *Medi-Cal Managed Care 2013 CAHPS Summary Report* contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

[24] Following administration of the CAHPS surveys, it was identified that Anthem Blue Cross was no longer contracted in San Joaquin and Stanislaus counties as of January 1, 2013. Therefore, data obtained from Anthem Blue Cross in San Joaquin County and Stanislaus County were excluded from the CAHPS 2013 results to limit potential for contract-termination induced bias.

To assess the overall performance of MCMC, HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about the MCPs' performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

CAHPS Global Rating Measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

CAHPS Composite Measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

Table 7.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

Table 7.1—CAHPS Measures Domains of Care

Measure	Domains of Care
Rating of Health Plan	Q
Rating of All Health Care	Q
Rating of Personal Doctor	Q
Rating of Specialist Seen Most Often	Q
Getting Needed Care	Q, A
Getting Care Quickly	Q, T
How Well Doctors Communicate	Q
Customer Service	Q
Shared Decision Making	Q

National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared

the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[25] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[26]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[27] using the following percentile distributions in Table 7.2.

Table 7.2—Star Ratings Crosswalk Used for CAHPS Measures

Star Rating	Adult and Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or above the 75th and below the 90th percentiles
★★★ Good	At or above the 50th and below the 75th percentiles
★★ Fair	At or above the 25th and below the 50th percentiles
★ Poor	Below the 25th percentile

Table 7.3 presents the MCMC aggregate star ratings for the global ratings and composite measures for the MCPs' adult and child Medicaid populations.[28]

Table 7.3—Medi-Cal Managed Care 2013 CAHPS National Comparisons Results

Measure	Adult Medicaid	Child Medicaid
Global Ratings		
Rating of Health Plan	★★	★★
Rating of All Health Care	★★	★
Rating of Personal Doctor	★★★	★★★
Rating of Specialist Seen Most Often	★★★	★★★★
Composite Measures		
Getting Needed Care	★★	★
Getting Care Quickly	★	★
How Well Doctors Communicate	★★	★
Customer Service	★★★	★★★

[25] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.

[26] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.

[27] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.

[28] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

The MCMC results showed generally *Poor* or *Fair* star rating performance across the global ratings and composite measures for both the adult and child populations when compared to national Medicaid data. The *Rating of Specialist Seen Most Often* for the child Medicaid survey was the exception and showed *Good* performance when compared to national data.

MCP Performance

Kaiser–San Diego County and Kaiser–Sacramento County were the only MCPs to demonstrate significantly higher performance than the MCMC average for eight of the nine CAHPS measures. In addition, when compared to national data, both of these MCPs' adult and child populations showed *Excellent* or *Very Good* star rating performance for all eight of the comparable measures. Central California Alliance for Health's combined rate for Monterey and Santa Cruz counties received significantly higher scores than the MCMC average for five of the nine measures.

Health Net in Sacramento County, Kern Family Health Care in Kern County, and Contra Costa Health Plan in Contra Costa County showed the greatest opportunity for improvement, demonstrating significantly lower performance than the MCMC average for four of the nine measures.

In assessing the MCPs' strengths and weaknesses across the CAHPS global ratings and composite measures, *Rating of Health Plan* and *Getting Care Quickly* had the highest number of MCPs that demonstrated *Poor* star rating performance for the adult population. Twenty-eight out of 44 MCPs demonstrated *Poor* performance for *Rating of Health Plan*, and 32 MCPs demonstrated *Poor* performance for *Getting Care Quickly*. For the child population, *Getting Care Quickly* and *How Well Doctors Communicate* had the highest number of MCPs that demonstrated *Poor* performance. Thirty-six MCPs demonstrated *Poor* performance for *Getting Care Quickly*, and 38 MCPs demonstrated *Poor* performance for *How Well Doctors Communicate*. These measures have the greatest opportunity for improvement.

Model Type Performance

In comparing the CAHPS results to national data, the COHS MCPs outperformed the GMC model and TPM types on three out of eight measures for the adult population. For the child population, the GMC model types outperformed the COHS MCPs and TPM types on seven out of eight measures. In addition, the GMC model types outperformed the COHS MCPs and TPM types and scored higher than the MCMC average for eight out of nine measures for the State Comparisons analysis.

Seniors and Persons with Disabilities Performance

HSAG's comparison of the SPD and non-SPD populations' CAHPS results to national data revealed that the adult SPD population outperformed the adult non-SPD population on six out of eight measures, and the child SPD population outperformed the child non-SPD population on three out of eight measures. Additionally, for the State Comparisons analysis, the SPD population scored higher than the non-SPD population, and its rate exceeded the MCMC average, for eight out of nine measures.

Specialty Managed Care Plan Satisfaction Survey Findings

AIDS Healthcare Foundation

AIDS Healthcare Foundation contracted with Decision Support Systems, LP (DSS), to conduct a CAHPS survey in 2013. DSS assessed the same areas for AIDS Healthcare Foundation that were assessed by HSAG for the full-scope MCPs; DSS also assessed *Health Promotion and Education* and *Coordination of Care*. The overall results of the survey showed that members are satisfied with the services being provided by the MCP. DSS identified the following items as most important in driving the overall MCP rating:

- Prescription plan (got needed prescriptions, prescription plan overall)
- Private home care provider (PHCP) nurse (satisfied with help from nurse, satisfied with treatment plan)
- How well doctors communicate (shows respect, spends time, clearly explains, listens carefully)
- Overall ratings (personal doctor, specialist)
- Customer service (gave information needed, treated with courtesy/respect)
- Getting care quickly (urgent care, got care within 24 hours)

Of the 14 items identified as most important, the following items were identified as ones with the most opportunity for improvement:

- PHCP nurse (satisfied with help from nurse, satisfied with treatment plan)
- How well doctors communicate (shows respect)
- Customer service (gave information needed, treated with courtesy/respect)
- Getting care quickly (urgent care, got care within 24 hours)

Family Mosaic Project

Family Mosaic Project had three separate locations during the review period. The MCP conducted a survey in 2012 for members at each location and assessed the following areas:

- General satisfaction
- Satisfaction with access to care
- Satisfaction with cultural sensitivity of staff
- Satisfaction with participation in treatment planning
- Outcomes of services
- Level of social connectedness

Overall, members were found to be satisfied with the MCP in the areas assessed in the survey. The MCP did not provide information on areas with an opportunity for improvement; however, HSAG's review of the results found that the average rating for the outcomes of services area for the Mission Family Center location was slightly lower than the other locations, suggesting that the MCP might benefit from assessing the factors leading to the lower rating and implement strategies to improve the rating.

Senior Care Action Network Health Plan

Senior Care Action Network Health Plan surveyed its members in 2012 regarding the following:

- Overall satisfaction with the MCP
- Overall MCP rating
- Whether the MCP had improved the member's ability to manage his/her health
- Whether the MCP had improved the member's ability to live independently
- Whether the member would recommend the MCP to a friend

Overall, Senior Care Action Network Health Plan received high ratings on all areas assessed.

Conclusions

DHCS demonstrates a commitment to monitor and improve MCMC beneficiaries' satisfaction through the administration of the CAHPS survey. The CAHPS survey plays an important role as a quality improvement tool for MCPs. The standardized data and results can be used to identify relative strengths and weaknesses in performance, identify areas for improvement, and trend progress over time.

Based on 2013 CAHPS performance, most full-scope MCPs have many opportunities to improve members' satisfaction with care and services since most measures received *Poor* or *Fair* star ratings when compared to national Medicaid data. Full-scope MCPs have the greatest opportunities for improvement on the *Rating of Health Plan, Getting Care Quickly*, and *How Well Doctors Communicate* measures. Low performance in these areas may point to issues with access to and timeliness of care.

Specialty MCPs generally had positive member satisfaction survey results, although some potential areas for improvement were identified.

Recommendations

Based on the review of the MCPs' member satisfaction survey results, HSAG provides the following recommendations for improvement to the MCPs:

- Consider conducting barrier analyses or focus groups to identify factors contributing to areas of low performance and implement interventions to address the priority barriers.
- Consider selecting a member satisfaction measure (or measures) as a formal quality improvement project as a strategy for improving results.
- For MCPs that demonstrated above-average performance, share initiatives and strategies that have been successful in meeting and exceeding members' expectations.
- For full-scope MCPs, review their 2013 MCP-specific CAHPS results report and develop strategies to address the identified priority areas for improvement.

Based on the review of the MCPs' member satisfaction survey results, HSAG provides the following recommendations to MCMC regarding its process for evaluating the quality of health care services provided by MCPs to MCMC beneficiaries:

- Consider implementing minimum performance requirements for CAHPS, similar to DHCS's assignment of performance measures, as a mechanism for addressing low MCP performance.

Conducting the EQRO Review

High-quality encounter data from Medi-Cal MCPs are necessary to evaluate and improve quality of care, assess utilization, develop appropriate capitated rates, and establish performance measures and acceptable rates of performance. DHCS relies on complete and accurate data for the management of MCMC. DHCS contracted with HSAG, to conduct an Encounter Data Validation (EDV) study for SFY 2012–13. This study included a review of the MCP information systems and processes as well as a comparative analysis of encounter data. All 22 full-scope MCPs and two specialty MCPs (AIDS Healthcare Foundation and Senior Care Action Network Health Plan) participated in the EDV study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[29] completed by the MCPs during their NCQA HEDIS Compliance Audit. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient

[29] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

- Pharmacy
- Long-Term Care

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

HSAG prepared a 2012–13 MCP-specific EDV study report for each MCP that contains the MCP-specific detailed findings and recommendations from the EDV study. Additionally, HSAG prepared a 2012–13 EDV aggregate report, which provides the detailed aggregate findings and recommendations from the study. A brief summary of the findings and opportunities for improvement is included below.

Encounter Data Validation Findings

Review of MCP Information Systems and Processes

The MCPs' Roadmap responses highlight the variety of approaches the MCPs use to implement and support DHCS's requirements for claims and encounter data submissions. In the Roadmaps, MCPs generally included the average number of monthly claims processed and a measure of the proportion of facility and provider claims that are submitted electronically versus on paper. The Roadmap responses included descriptions of a variety of substantively different metrics used by the MCPs to monitor and report the efficiency of some of their processes.

The MCPs responded to items on the questionnaire that were categorized into the following subsections: Submitting Encounter Data to DHCS, Handling Submission Information from DHCS, and Encounter Data Submission from Capitated Providers. Most MCPs reported submitting monthly encounter data files. A common challenge reported by the MCPs was mapping internal, inconsistent, or incorrect codes to valid codes accepted by DHCS before submission to DHCS.

Comparative Analysis of Encounter Data

The goal of the comparative analysis was to evaluate the extent to which encounter data in the DHCS data warehouse are complete and accurate when compared to data stored in the MCPs' data systems. The comparative analysis examined four encounter data types—Medical/Outpatient, Hospital/Inpatient, Pharmacy, and Long-Term Care (LTC)—and included data with dates of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012.

General Encounter Information

Following are general findings related to HSAG's assessment and analysis of the encounter data:

- Some MCPs were submitting the LTC encounters under the Hospital/Inpatient claim type. Additionally, MCPs identified LTC records using a variety of methods, which included using the provider type, Place of Service Code, Type of Bill code, etc.
- DHCS data did not contain Outpatient records, as identified by *Claim Type* of "1" (Outpatient), for Contra Costa Health Plan, Community Health Group Partnership Plan, Care1st Partner Plan, and Senior Care Action Network Health Plan.
- Currently, there is no clear documentation on the edits that the fiscal intermediary, performs when processing the MCPs' data.
- There is no clear documentation on the edits that Information Technology Services Division (ITSD) at DHCS performs when processing the MCPs' data.
- Currently, the encounter data are submitted to DHCS in three formats: 35C file format, Encounter Data layout, and National Council for Prescription Drug Programs format. Data in all three formats were converted to the 35C format and stored in the DHCS data warehouse.

Record Completeness

Record-level data completeness was evaluated by investigating the record omission[30] and record surplus[31] in DHCS's data. Overall, the LTC claim type had the most complete data with the lowest record omission and record surplus rates, while the Pharmacy claim type had the most incomplete data with the highest record omission and record surplus rates. The record completeness varied considerably among the MCPs for each of the four claim types.

[30] Record omission is the number and percentage of records present in the files submitted by MCPs that were not found in the DHCS data warehouse.

[31] Record surplus is the number and percentage of records present in the DHCS data warehouse but not in the files submitted by the MCPs.

Data Element Completeness and Accuracy

Element-level completeness was evaluated by the element omission[32] and element surplus[33] rates for the key data elements. Overall, the element completeness was good, with statewide element omission and element surplus rates below 4 percent for nearly all of the key data elements. Fields with relatively incomplete data included the *Rendering Provider Number* in the Medical/Outpatient claim type as well as the *Referring/Prescribing/Admitting Provider Number* and *Provider Type* in the Pharmacy claim type. At the MCP level, there were considerably large variations and reasons for the incompleteness, which varied depending on the data element and the MCP.

Element-level accuracy was determined by comparing the values of key data elements for records with data present in both DHCS's and the MCPs' records. Overall, the majority of the key data elements in each of the four claim types had statewide element accuracy rates above 95 percent. The *Billing/Reporting Provider Number* and *Referring/Prescribing/Admitting Provider Number* data elements had relatively low element accuracy rates. While performance varied widely across the MCPs, three MCPs had significantly low performance with all-element accuracy rates[34] less than 3 percent for each claim type.

Additional findings related to data element completeness and accuracy were:

- For the data elements *Billing/Reporting Provider Number*, *Referring/Prescribing/Admitting Provider Number*, and *Rendering Provider Number*, the field length is 12 characters based on the Encounter Data Element Dictionary. However, these data elements were saved as a 10-character field in the DHCS data warehouse.
- DHCS's data layout restricts the MCPs to submit a maximum of two diagnosis codes, which resulted in the full diagnosis profile for the services rendered not always being captured.
- Some MCPs did not submit any values to DHCS for some data elements, such as *Secondary Diagnosis Code*, *Primary Surgical Procedure Code*, and *Secondary Surgical Procedure Code*.
- The Encounter Data Element Dictionary does not contain the data element *Revenue Code*. Therefore, the actual revenue codes were populated in the *Accommodation Code* or *Procedure Code* field in DHCS's data. Additionally, the Encounter Data Element Dictionary does not contain the data element *Line Number*.
- For the *Drug/Medical Supply* data element in the Pharmacy claim type, the value of "9999MZZ" was populated in the data the MCPs submitted to HSAG but was omitted from DHCS's data.

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[32] Element omission rate is the percentage of records with values present in the files submitted by MCPs but not in the DHCS data warehouse.

[33] Element surplus rate is the percentage of records with values present in the DHCS data warehouse but not in the files submitted by MCPs.

[34] All-element accuracy rate is the percentage of records present in both data sources with exactly the same values for all selected key data elements relevant to each encounter data type.

- In the initial analysis, *Days of Stay* was considered a key data element. Because the values populated in this element in DHCS's data are calculated by DHCS, this data element was excluded from the EDV study. During the preliminary file review, HSAG noted that the MCPs calculated the *Days of Stay* using the *Header Service From Date* and *Header Service To Date*, the *Detail Service From Date* and *Detail Service To Date*, the *Admission Date* and *Discharge Date*, as well as the quantity for the records with a *Revenue Code* indicating room and board.

Recommendations

Based on its review, HSAG recommends the following for DHCS to improve encounter data quality—broken out into separate categories of general encounter information, record completeness, and element completeness and accuracy:

General Encounter Information

- DHCS should clarify with the MCPs on how to identify and submit LTC records to DHCS, so that all MCPs can define LTC records uniformly and DHCS can easily identify them. MCPs not offering LTC services may have some interim LTC records while DHCS moves members to the FFS program. DHCS's clarification should include these interim LTC records, too.
- DHCS needs to evaluate whether it is reasonable that Contra Costa Health Plan, Community Health Group Partnership Plan, Care1st Partner Plan, and Senior Care Action Network Health Plan would not have outpatient services records. If not, DHCS should work with the MCPs to investigate the causes and correct the issues.
- DHCS should verify whether there are any CHDP encounters classified under the incorrect claim type for Santa Clara Family Health Plan.
- DHCS should request documentation on the edits that the fiscal intermediary performs so that DHCS can review and modify the existing edits if needed.
- DHCS should request documentation from ITSD on edits ITSD performs when processing the MCPs' data so DHCS can review and modify existing edits if needed.
- DHCS should investigate the adjudication history for each of the MCPs. If an MCP does not provide the adjudication history to DHCS, DHCS should follow up with the MCP and clarify that the MCP should follow DHCS's requirements to submit the updated information for a record if it has been adjudicated after the submission to DHCS. For the MCPs with adjudication history in DHCS's data, DHCS should develop an automated process to identify the final adjudication records.
- When an MCP experiences a system change, it is likely that the encounter data submitted to DHCS will be impacted. DHCS should consider requesting the MCPs to notify DHCS about any major system changes and create processes and procedures to monitor the quality of the encounter data.

- To improve the quality and data processing efficiency, DHCS should consider reducing the number of formats used for data submission.

Record Completeness

To monitor record completeness, DHCS should routinely examine the monthly claim volume based on dates of service or adjudication dates by claim type to detect any abnormalities. For some claim types, the evaluation could be done for certain subcategories (e.g., for the Medical/Physician encounters, DHCS can check the monthly volume by provider type; place of service; services type, such as vision, lab, transportation, etc.). These quality checks are crucial to ensure encounter data completeness, especially when the MCPs make system changes.

Element Completeness and Accuracy

- To improve element completeness and accuracy, DHCS should review the existing system edits applied by DHCS or its fiscal intermediary and make changes as needed (e.g., add system edits to identify invalid values, avoid truncating any of the values submitted by the MCPs).
- DHCS should consider increasing the length of *Billing/Reporting Provider Number*, *Referring/Prescribing/Admitting Provider Number*, and *Rendering Provider Number* to 12 characters in the data warehouse to avoid truncation of the values MCPs submit. In the meantime, DHCS should encourage the MCPs to submit the providers' 10-digit National Provider Identifier whenever possible.
- For the MCPs with a high percentage of missing values for the *Rendering Provider Number* and *Referring/Prescribing/Admitting Provider Number* data elements, DHCS should evaluate whether the MCPs should change their processes and procedures to collect and submit values for these two data elements.
- DHCS should verify if the *Referring/Prescribing/Admitting Provider Number, Billing/Reporting Provider Number,* and/or *Rendering Provider Number* should be the same for specific records. DHCS also should apply system edits to detect invalid provider numbers.
- DHCS should store additional diagnosis code fields to capture the full diagnosis profile for the services rendered. In addition, DHCS should apply a system edit to recognize invalid diagnosis codes, such as "12345."
- DHCS should set up system edits to detect when MCPs do not submit any values for certain data elements (i.e., *Secondary Diagnosis Code*, *Primary Surgical Procedure Code*, and *Secondary Surgical Procedure Code*.)
- DHCS should add the data element *Revenue Code* to the Encounter Data Element Dictionary. Additionally, DHCS should add the *Line Number* data element to the Encounter Data Element Dictionary so that DHCS can recognize the line level information from the MCPs.

- DHCS's system edits/audit rules should be reviewed and updated as necessary. For example, DHCS should determine if *Rendering Provider Number* or *Provider Specialty* values are removed from the data that the MCPs submitted to DHCS if the *Provider Type* values do not require these data elements to be populated.
- DHCS should investigate the reasons for the element omission on the *Drug/Medical Supply* data element.
- DHCS should determine a standard way to determine the *Days of Stay* so that the information is consistent and comparable between the MCPs.

9. Overall Findings, Conclusions, and Recommendations Related to External Quality Review Activities

HSAG offers EQR activity-specific conclusions and recommendations for improvement for the MCPs and MCMC based on its analysis of aggregated data from three federally mandated EQR activities and two optional EQR activities:

Mandatory External Quality Review Activities

Review of Compliance Standards

To assess performance related to the quality and timeliness of, and access to, care, HSAG evaluated the MCPs' compliance with State and federal requirements by reviewing the most recent DHCS monitoring reports available as of June 30, 2013, for each MCP related to compliance monitoring standards within the CFR.

Findings and Conclusions for Compliance Standards

Overall, the MCPs were compliant with most of the compliance monitoring standards, and some MCPs were compliant with all of the standards. MCPs generally had appropriate resources and written policies and procedures in place to support a quality improvement program. Additionally, MCPs generally provided evidence that the policies and procedures were implemented in accordance with the requirements.

As in prior years, most of the findings from the reviews impacted the access and timeliness domains of care. MCPs resolved most of the findings through the corrective action plan process or by providing documentation of the actions taken to resolve the findings as part of DHCS's follow-up process. Several MCPs provided documentation of actions they took to correct unresolved findings noted in their 2011–12 MCP-specific evaluation reports as part of HSAG's process for developing the 2012–13 MCP-specific evaluation reports. The areas with the most opportunity for improvement were Access and Availability/Access and Availability of Services, Member Rights/Member's Rights and Responsibilities—Under the Grievance System, Quality Management/Quality Improvement System, and Utilization Management.

Recommendations for Compliance Standards

Based on the compliance standards results, HSAG recommends that MCPs should do the following for improved compliance with federal and State standards:

- Address areas of noncompliance in MCP work plans and ensure that the MCPs take corrective action and continually monitor deficiencies.
- Ensure that they display all required provider accessibility indicator information on their MCP websites.
- Ensure that they develop, implement, and monitor access and availability policies and procedures.
- Ensure that they develop, implement, and monitor grievance system policies and procedures.
- Ensure that they document all required information in the Quality Improvement/Utilization Management Committee meeting minutes.
- Ensure that they have the required specialist provider representation on their Quality Improvement/Utilization Management committees.

Based on the compliance standards results, HSAG provides the following recommendations to MCMC regarding its oversight of the MCPs' compliance with federal and State standards:

- Continue to implement DHCS's new monitoring protocols to ensure that MCPs' actively and continuously monitor progress in addressing findings and deficiencies until these issues are fully resolved.
- Ensure a comprehensive audit is conducted at least once within a three-year period with all MCPs.
- Compare the compliance tool used for the various DHCS reviews to the CFR to ensure all federal requirements are assessed within the three-year required time frame.

Validation of Performance Measures

HSAG validated performance measures required by DHCS to evaluate the accuracy of performance measure results reported by the MCPs. The validation also determined the extent to which MCMC-specific performance measures calculated by the MCPs followed specifications established by the program. HSAG reviewed the performance measure rates to assess MCPs' impact on improving health outcomes of members.

Findings and Conclusions for Performance Measures

Full-scope and specialty MCPs were able to report valid rates for their DHCS-required measures. Overall, MCMC's full-scope MCP 2013 performance measure results were similar to reporting years 2011 and 2012 in that most of the MCMC weighted averages were between the DHCS-established minimum performance levels (MPLs) and high performance levels (HPLs). MCMC as a whole demonstrated some strengths as well as areas needing improvement. The top three performance measure rates, those with the smallest differences between the MCMC weighted averages and the DHCS-established HPLs, were *Avoidance of Antibiotic Treatment in Adults*

With Acute Bronchitis, *Comprehensive Diabetes Care—LDL-C Screening*, and *Use of Imaging Studies for Low Back Pain*.

MCMC weighted averages for the following measures were below the DHCS-established MPLs in 2013, which is the first year the weighted averages for these measures were below the MPLs:

- All three *Annual Monitoring for Patients on Persistent Medications* measures
- All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- *Prenatal and Postpartum Care—Postpartum Care*

The MCMC weighted average rate for the *Prenatal and Postpartum Care—Postpartum Care* measure declined significantly from 2012 to 2013, which is what led to the rate moving from above the MPL in 2012 to below the MPL in 2013. Although the MCMC weighted average rate for the *Annual Monitoring for Patients on Persistent Medications—ACE* measure declined significantly from 2012 to 2013, HSAG cannot accurately assess if the statistically significant decline in the rate for this measure is what led to the rate being below the MPL in 2013 because 2013 was the first year the MCPs were held to the MPL for this measure.

MCMC had three measures with statistically significant improvement in weighted average rates from 2012 to 2013 compared to seven measures from 2011 to 2012. In addition to the significant decline in rates for the *Prenatal and Postpartum Care—Postpartum Care* and *Annual Monitoring for Patients on Persistent Medications—ACE* measures, the MCMC weighted average rates for two other quality measures, *Cervical Cancer Screening* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, declined significantly from 2012 to 2013. The performance comparison results show that overall, MCMC had fewer measures with significant improvement in 2013 when compared to 2012 and more measures with weighted average rates that declined significantly in 2013 when compared to 2012.

In compliance with Welfare and Institutions (W&I) Code, Section 14182(b)(17),[35] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) populations on a selected group of performance measures. Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal-only SPDs into managed care. This enrollment began in June 2011 and was completed by June 2012.

The overall rates for the SPD population were better than the rates for the non-SPD population for the *Comprehensive Diabetes Care* and *Annual Monitoring for Patients on Persistent Medications* measures.

[35] Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care plan and for the subset of enrollees who are Seniors and Persons with Disabilities. Managed care plan performance measures may include HEDIS measures; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

This is consistent with what HSAG has observed in other states and may be attributed to SPD members having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. Conversely, SPDs had higher *All-Cause Readmissions* rates when compared to the non-SPD population, which is also expected based on the greater and often more complicated health needs of these members. Additionally, the SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners* measures in several counties were lower than the non-SPD rates. The lower rates for these measures 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.

Specialty MCPs performed well on reported measures, with none of the measures having rates below the MPLs, where applicable.

Recommendations for Performance Measures

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

- Ensure that the rendering provider detail is included on all submitted claims and encounters, especially for services performed at multispecialty and group practices. Inclusion of the rendering provider is important for measures that require a specific provider specialty, such as:
  - The identification of a primary care provider for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Weight Assessment and Counseling for Nutrition and Physical Activity*; and *Children and Adolescent's Access to Primary Care Practitioners*.
  - The identification of a nephrologist, optometrist, and ophthalmologist for the *Comprehensive Diabetes Care* measures.

  Improving capture of the rendering provider can decrease the burden of medical record review for measures that allow for hybrid reporting.
- Explore the use of supplemental data with greater coordination and oversight to enhance HEDIS reporting. More stringent requirements will be fully enforced for HEDIS 2014, which could invalidate a database if not properly validated by the MCP.
- Closely monitor timelines, milestones, and deliverables of contracted providers and certified software vendors. MCPs should consider implementing sanctions for vendors that do not meet contractual requirements.
- Work to increase electronic data submission from providers.
- Improve reporting accountability by clearly documenting the data audit process.

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

- MCPs need to place a greater emphasis on efforts that are data-driven and can actually improve health outcomes rather than approaching development of HEDIS improvement plans as an exercise in documentation.
- MCPs should select performance measures with poor rates as the focus for formal QIPs in order to achieve acceptable performance for all measures and implement rapid cycle quality improvement methods.
- MCPs need to identify barriers based on available data and link improvement strategies to the barriers having the greatest negative effect on the targeted HEDIS rate.
- MCPs should evaluate the SPD and non-SPD populations during their barrier analyses and develop targeted interventions when appropriate.
- MCPs need to consider evidence-based strategies when selecting interventions.
- MCPs need to track and monitor interventions and critically evaluate intervention effectiveness to identify those interventions that have been successful, those that should be modified, and those that should be discontinued.
- MCPs should consider working with MCMC and the EQRO as a source of more intensive technical assistance for measures that continue to demonstrate low performance over consecutive years.

Based on the review of the 2013 HEDIS results, HSAG provides the following recommendations to MCMC regarding its oversight of the MCPs' performance on External Accountability Set measures:

- 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.
- Engage in the following efforts related to improvement plans (IPs):
  - Continue to thoroughly assess IPs submitted by the MCPs to ensure thorough barrier analyses have been completed and that the identified interventions address the prioritized barriers.
  - Continue to assess if development of an IP is needed in instances where an MCP has a QIP related to a performance measure with a rate below the MPL and consider conducting quarterly monitoring, at minimum, of the MCP's QIP to assess if progress is being made on moving the rate above the MPL.

  - Monitor, at least quarterly, the MCPs' progress on implementing IPs to ensure the MCPs are engaging in rapid cycle improvement methods to improve performance on the measures.
- Identify State-level barriers and develop strategies for addressing the barriers.

Validation of Performance Improvement Projects

DHCS refers to performance improvement projects as quality improvement projects (QIPs). HSAG reviewed each MCP's QIPs to ensure that the MCPs designed, conducted, and reported projects in a methodologically sound manner, to assess for real improvements in care and services, in order to give confidence in the reported results. HSAG also assessed MCPs' QIP outcomes and their impact on improving care and services provided to members.

Findings and Conclusions for Performance Improvement Projects

The MCPs demonstrated excellent application of most activities in the QIP Design stage, including selecting appropriate study topics, clearly defining their study questions and study indicators, correctly identifying their study populations, and using valid sampling techniques. QIP validation results also showed that MCPs demonstrated a strong application of the Implementation stage. Most MCPs provided sufficient data analysis and identified appropriate improvement strategies. Some of the MCPs implemented improvement strategies that resulted in positive outcomes, including targeted case management, pay-for-performance strategies, and use of quality improvement tools throughout the QIP process.

During the reporting period, only 3 of the 22 QIPs that could be assessed for improvement achieved statistically significant improvement over baseline. Of the 12 QIPs that could be assessed for sustained improvement, 10 achieved sustained improvement, meaning that the statistically significant improvement in performance achieved over baseline was maintained or increased in the current measurement period. MCMC, the MCPs, and HSAG had focused discussions on conducting regular causal/barrier analyses, identifying appropriate improvement strategies, and effectively evaluating each intervention. The technical assistance provided by HSAG through the focused discussions and the ongoing technical assistance provided by MCMC should increase the likelihood of improved QIP outcomes over time.

Overall, MCPs provided the required QIP documentation; however, some MCPs needed to resubmit their QIPs multiple times because they repeatedly did not provide the required information. The MCPs have the opportunity to improve upon the thoroughness and accuracy of the QIP documentation and to review and respond to all feedback from HSAG in the QIP Validation Tool so the MCPs can meet all QIP documentation requirements.

Recommendations for Performance Improvement Projects

Based on the review of the QIP validation and outcome results, HSAG provides the following recommendations to the MCPs for improving performance:

- Review the QIP Completion Instructions to ensure that all required documentation is included in the QIP Summary Form to avoid having to resubmit their QIPs.
- Ensure that they conduct routine causal/barrier analysis and include the documentation when submitting the QIP for validation.
- Evaluate each QIP intervention and document the results of the evaluation in the QIP Summary Form. Additionally, document how the evaluation results impacted the interventions (i.e., identify which were successful, which needed to be modified, and which should be discontinued).
- Implement rapid cycle improvement strategies to increase the likelihood that statistically significant and sustained improvement will be achieved. MCPs should:
  - Ensure they identify all relevant barriers.
  - Ensure that interventions are directly linked to the high-priority barriers.
  - Assess interim outcomes quarterly, at minimum, to determine if interventions should be revised, standardized, scaled up, or discontinued.

Additionally, MCPs should ensure that QIP topics address areas in need of improvement (e.g., a performance measure with a rate below the MPL, an area receiving low satisfaction ratings).

Based on the review of the QIP validation and outcome results, HSAG provides the following recommendations to MCMC regarding its oversight of the MCPs' performance on QIPs:

- Continue to assess the appropriateness of MCPs' proposed QIP topics to ensure their relevance to the MCMC population; that the topics address areas in need of improvement; and that the projects have the ability to improve member health, functional status, or satisfaction.
- Continue to provide technical assistance to the MCPs, in collaboration with the EQRO, to support the MCPs in designing valid QIPs and increasing the likelihood of statistically significant and sustained improvement.
- For MCPs that have QIP topics related to performance measures with rates below the MPLs, consider conducting quarterly monitoring, at minimum, of the MCPs' QIPs to assess if progress is being made on moving the rates above the MPLs.

Optional External Quality Review Activities

Administration of Health Care Consumer Survey

HSAG administered the 2013 CAHPS survey to both adult beneficiaries and the parents or caretakers of child members for all full-scope MCPs. Specialty MCPs were not included in the CAHPS survey administration since specialty MCPs are required to administer their own annual consumer satisfaction survey to evaluate their Medi-Cal members' satisfaction regarding care and services provided by the MCPs. HSAG reviewed the results of the CAHPS survey and the specialty MCP satisfaction surveys to assess MCMC beneficiaries' level of satisfaction with the quality and timeliness of, and access to, health care services being provided to them.

Findings and Conclusions for Health Care Consumer Survey

The MCMC CAHPS survey results showed generally *Poor* or *Fair* star rating performance across the global ratings and composite measures for both the adult and child populations when compared to national Medicaid data. The *Rating of Specialist Seen Most Often* for the child Medicaid survey was the exception, which showed *Good* performance when compared to national data.

HSAG's comparison of the SPD and non-SPD populations' CAHPS results to national data revealed that the adult SPD population outperformed the adult non-SPD population on six out of eight measures, and the child SPD population outperformed the child non-SPD population on three out of eight measures. Additionally, for the State Comparisons analysis, the SPD population scored higher than the non-SPD population, and its rate exceeded the MCMC average, for eight out of nine measures.

Based on 2013 CAHPS performance, most MCPs have many opportunities to improve members' satisfaction with care and services since most measures received *Poor* or *Fair* star ratings when compared to national Medicaid data. MCPs have the greatest opportunities for improvement on the *Rating of Health Plan*, *Getting Care Quickly*, and *How Well Doctors Communicate* measures. Low performance in these areas may point to issues with access to and timeliness of care.

Specialty MCPs generally had positive member satisfaction survey results, although some potential MCP-specific areas for improvement were identified.

Recommendations for Health Care Consumer Survey

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

- Consider conducting barrier analyses or focus groups to identify factors contributing to areas of low performance and implement interventions to address the priority barriers.

- Consider selecting a member satisfaction measure (or measures) as a formal QIP as a strategy for improving results.
- For MCPs that demonstrated above-average performance, share initiatives and strategies that have been successful in meeting and exceeding members' expectations.
- For full-scope MCPs, review their 2013 MCP-specific CAHPS results report and develop strategies to address the identified priority areas for improvement.

Based on the review of the 2013 CAHPS survey results, HSAG provides the following recommendations to MCMC regarding its process for evaluating the quality of health care services provided by MCPs to MCMC beneficiaries:

- Consider implementing minimum performance requirements for CAHPS, similar to DHCS's assignment of performance measures, as a mechanism for addressing low MCP performance.

Validation of Encounter Data

HSAG reviewed the MCPs' information systems and processes and conducted a comparative analysis of encounter data to assess the extent to which encounters submitted to DHCS by its contracted MCPs are complete and accurate.

Findings and Conclusions for Encounter Data Validation

HSAG obtained the HEDIS Roadmap completed by the MCPs during their NCQA HEDIS Compliance Audit. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse. The MCPs' Roadmap responses highlight the variety of approaches the MCPs use to implement and support DHCS's requirements for claims and encounter data submissions. In the Roadmaps, MCPs generally included the average number of monthly claims processed and a measure of the proportion of facility and provider claims that are submitted electronically versus on paper. The Roadmap responses included descriptions of a variety of substantively different metrics used by the MCPs to monitor and report the efficiency of some of their processes.

The MCPs responded to items on the questionnaire that were categorized into the following subsections: Submitting Encounter Data to DHCS, Handling Submission Information from DHCS, and Encounter Data Submission from Capitated Providers. Most MCPs reported submitting monthly encounter data files. A common challenge reported by the MCPs was mapping internal, inconsistent, or incorrect codes to valid codes accepted by DHCS before submission to DHCS.

The goal of the comparative analysis was to evaluate the extent to which encounter data in the DHCS data warehouse were complete and accurate when compared to data stored in the MCPs' data systems. The comparative analysis examined four encounter data types—Medical/Outpatient, Hospital/Inpatient, Pharmacy, and Long-Term Care (LTC)—and included data with dates of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012.

Record-level data completeness was evaluated by investigating the record omission[36] and record surplus[37] in DHCS's data. Overall, the LTC claim type had the most complete data with the lowest record omission and record surplus rates, while the Pharmacy claim type had the most incomplete data with the highest record omission and record surplus rates. The record completeness varied considerably among the MCPs for each of the four claim types.

Element-level completeness was evaluated by the element omission[38] and element surplus[39] rates for the key data elements. Overall, the element completeness was good, with statewide element omission and element surplus rates below 4 percent for nearly all of the key data elements. Fields with relatively incomplete data included the *Rendering Provider Number* in the Medical/Outpatient claim type as well as the *Referring/Prescribing/Admitting Provider Number* and *Provider Type* in the Pharmacy claim type. At the MCP level, there were considerably large variations and reason(s) for the incompleteness, which varied depending on the data element and the MCP.

Element-level accuracy was determined by comparing the values of key data elements for records with data present in both DHCS's and the MCPs' records. Overall, the majority of the key data elements in each of the four claim types had statewide element accuracy rates above 95 percent. The *Billing/Reporting Provider Number* and *Referring/Prescribing/Admitting Provider Number* data elements had relatively low element accuracy rates. While performance varied widely across the MCPs, three MCPs had the lowest performance with all-element accuracy rates[40] less than 3 percent for each claim type.

[36] Record omission is the number and percentage of records present in the files submitted by MCPs that were not found in the DHCS data warehouse.

[37] Record surplus is the number and percentage of records present in the DHCS data warehouse but not in the files submitted by the MCPs.

[38] Element omission rate is the percentage of records with values present in the files submitted by the MCPs but not in the DHCS data warehouse.

[39] Element surplus rate is the percentage of records with values present in the DHCS data warehouse but not in the files submitted by MCPs.

[40] All-element accuracy rate is the percentage of records present in both data sources with exactly the same values for all selected key data elements relevant to each encounter data type.

Recommendations for Encounter Data Validation

Based on its review, HSAG recommends the following for DHCS to improve encounter data quality—broken out into separate categories of general encounter information, record completeness, and element completeness and accuracy:

General Encounter Information

- DHCS should clarify with the MCPs how to identify and submit LTC records to DHCS, so that all MCPs can define LTC records uniformly and DHCS can easily identify them. MCPs not offering LTC services may have some interim LTC records while DHCS moves members to the fee-for-service program. DHCS's clarification should include these interim LTC records, too.
- DHCS needs to evaluate whether it is reasonable that Contra Costa Health Plan, Community Health Group Partnership Plan, Care1st Partner Plan, and Senior Care Action Network Health Plan would not have outpatient services records. If not, DHCS should work with the MCPs to investigate the causes and correct the issues.
- DHCS should verify whether there are any Child Health and Disability Prevention (CHDP) Program encounters classified under the incorrect claim type for CHDP encounters for Santa Clara Family Health Plan.
- DHCS should request documentation on the edits that the fiscal intermediary performs so that DHCS can review and modify the existing edits if needed.
- DHCS should request documentation from its Information Technology Services Division (ITSD) on edits ITSD performs when processing the MCPs' data so DHCS can review and modify existing edits if needed.
- DHCS should investigate the adjudication history for each of the MCPs. If an MCP does not provide the adjudication history to DHCS, DHCS should follow up with the MCP and clarify that the MCP should follow DHCS's requirements to submit the updated information for a record if it has been adjudicated after the submission to DHCS. For the MCPs with adjudication history in DHCS's data, DHCS should develop an automated process to identify the final adjudication records.
- When an MCP experiences a system change, it is likely that the encounter data submitted to DHCS will be impacted. DHCS should consider requesting the MCPs to notify DHCS about any major system changes and create processes and procedures to monitor the quality of the encounter data.
- To improve the quality and data processing efficiency, DHCS should consider reducing the number of formats used for data submission.

Record Completeness

To monitor record completeness, DHCS should routinely examine the monthly claim volume based on dates of service or adjudication dates by claim type to detect any abnormalities. For some claim types, the evaluation could be done for certain subcategories (e.g., for the Medical/Physician encounters, DHCS can check the monthly volume by provider type; place of service; services type, such as vision, lab, transportation, etc.). These quality checks are crucial to ensure encounter data completeness, especially when the MCPs make system changes.

Element Completeness and Accuracy

- To improve element completeness and accuracy, DHCS should review the existing system edits applied by DHCS or its fiscal intermediary and make changes as needed (e.g., add system edits to identify invalid values, avoid truncating any of the values submitted by the MCPs).
- DHCS should consider increasing the length of *Billing/Reporting Provider Number*, *Referring/Prescribing/Admitting Provider Number*, and *Rendering Provider Number* to 12 characters in the data warehouse to avoid truncation of the values MCPs submit. In the meantime, DHCS should encourage the MCPs to submit the providers' 10-digit National Provider Identifier whenever possible.
- For the MCPs with a high percentage of missing values for the *Rendering Provider Number* and *Referring/Prescribing/Admitting Provider Number* data elements, DHCS should evaluate whether the MCPs should change their processes and procedures to collect and submit values for these two data elements.
- DHCS should verify if the *Referring/Prescribing/Admitting Provider Number, Billing/Reporting Provider Number,* and/or *Rendering Provider Number* should be the same for specific records. DHCS also should apply system edits to detect invalid provider numbers.
- DHCS should store additional diagnosis code fields to capture the full diagnosis profile for the services rendered. In addition, DHCS should apply a system edit to recognize invalid diagnosis codes, such as "12345."
- DHCS should set up system edits to detect when MCPs do not submit any values for certain data elements (i.e., *Secondary Diagnosis Code*, *Primary Surgical Procedure Code*, and *Secondary Surgical Procedure Code*.)
- DHCS should add the data element *Revenue Code* to the Encounter Data Element Dictionary. Additionally, DHCS should add the *Line Number* data element to the Encounter Data Element Dictionary so that DHCS can recognize the line level information from the MCPs.
- DHCS's system edits/audit rules should be reviewed and updated as necessary. For example, DHCS should determine if *Rendering Provider Number* or *Provider Specialty* values are removed

from the data that the MCPs submitted to DHCS if the *Provider Type* values do not require these data elements to be populated.

- DHCS should investigate the reasons for the element omission on the *Drug/Medical Supply* data element.
- DHCS should determine a standard way to determine the *Days of Stay* so that the information is consistent and comparable between the MCPs.

10. Overall Findings, Conclusions, and Recommendations Related to Domains of Care

Findings, Conclusions, and Recommendations Regarding Health Care Quality, Access, and Timeliness

CMS chose the domains of quality, access, and timeliness as keys to evaluating the performance of Medicaid MCPs. HSAG provides overall findings, conclusions, and recommendations regarding MCMC's aggregate performance during the review period for each domain of care. Please note that when a performance measure, CAHPS measure, or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure, CAHPS measure, or QIP under all applicable domains of care.

Quality

As mentioned earlier in this report, CMS's definition of the quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP in some areas, such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, DHCS monitors aspects of an MCP's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems. DHCS also uses the results of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

For this report, HSAG used the results from compliance review standards related to measurement and improvement, the MCMC 2013 quality-related performance measure weighted average rates (which reflect 2012 measurement data), QIP outcome results for QIPs falling into the quality domain of care, and member satisfaction survey results to assess MCMC's performance related to the quality domain of care.

MCMC's compliance monitoring review findings during the review period revealed that similar to prior years, overall, MCPs met most or all of the standards for quality management and organizational capacity, both of which support the delivery of quality care. MCPs appeared to have appropriate resources and written policies and procedures to support a quality improvement program.

All MCPs were able to successfully report valid HEDIS 2013 performance measure rates. Although MCMC had one quality measure in 2012 with a weighted average rate that exceeded the DHCS-established HPL, MCMC had no quality measures in 2013 with weighted average rates that exceeded the HPLs. In 2012, no quality measures had weighted average rates below the MPLs; however, in 2013, the weighted average rates for the following quality measures were below the MPLs:

- All three *Annual Monitoring for Patients on Persistent Medications* measures
- *Prenatal and Postpartum Care—Postpartum Care*

The MCMC weighted average rate for the *Prenatal and Postpartum Care—Postpartum Care* measure declined significantly from 2012 to 2013, which is what led to the rate moving from above the MPL in 2012 to below the MPL in 2013. Although the MCMC weighted average rate for the *Annual Monitoring for Patients on Persistent Medications—ACE* measure declined significantly from 2012 to 2013, HSAG cannot accurately assess if the statistically significant decline in the rate for this measure is what led to the rate being below the MPL in 2013 because 2013 was the first year the MCPs were held to the MPL for this measure.

MCMC had three quality measures with statistically significant improvement in weighted average rates from 2012 to 2013 compared to seven quality measures from 2011 to 2012. In addition to the significant decline in rates for the *Prenatal and Postpartum Care—Postpartum Care* and *Annual Monitoring for Patients on Persistent Medications—ACE* measures, the MCMC weighted average rates for two other quality measures, *Cervical Cancer Screening* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, declined significantly from 2012 to 2013. The performance comparison results show that overall, MCMC had fewer quality measures with significant improvement in 2013 when compared to 2012 and more measures with weighted average rates that declined significantly in 2013 when compared to 2012. Additionally, overall, MCMC performance related to required quality measures was average, meaning that most of the measures' rates were above the MPLs and below the HPLs.

Most MCPs' IPs for quality measures with rates below the MPLs in 2012 were successful at improving the rates to above the MPLs in 2013; however, one MCP had seven IPs for quality measures, and none of them were successful in bringing the rates above the MPLs.

HSAG reviewed the MCPs' IPs and found that unlike in previous years, most MCPs conducted new barrier analyses and identified new interventions for existing IPs. Additionally, most MCPs used data to drive their IPs and identified achievable outcomes. The MCPs' improvements in IP development

are likely a result of MCMC implementing a more rigorous IP review and approval process and requiring MCPs to develop IPs driven by data analyses and identify interventions to address the priority barriers.

The overall rates for the SPD population were better than the rates for the non-SPD population for the *Comprehensive Diabetes Care* and *Annual Monitoring for Patients on Persistent Medications* measures, which all fall into the quality domain of care. This is consistent with what HSAG has observed in other states and may be attributed to SPD members having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. Conversely, the SPD rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care, was significantly higher when compared to the non-SPD rate. This is also expected based on the greater and often more complicated health needs of these members; however, for MCPs with higher readmission rates for the SPD population, HSAG recommends that the MCPs assess the factors leading to the higher readmission rates to ensure the needs of the SPD population are being met.

Thirty-three QIPs that progressed to the Outcomes stage fall into the quality domain of care. Twenty-two of the QIPs were assessed for statistically significant improvement, and only three of them achieved statistically significant improvement over baseline. Eleven of the QIPs were assessed for sustained improvement, and nine of them achieved sustained improvement for at least one of the study indicators. It appears that once statistically significant improvement is achieved, the successful improvement strategies are improved upon or maintained; however, MCPs continue to struggle with achieving the initial statistically significant improvement over baseline. While the outcomes show that QIPs are positively impacting the quality of care being provided to members, there are opportunities for improvement.

All CAHPS measures fall into the quality domain of care. Medi-Cal full-scope MCPs' CAHPS survey results showed below-average performance across most measures for both the adult and child populations when compared to national Medicaid data. The child *Rating of Specialist Seen Most Often* measure was the exception, with this measure receiving a *Good* rating when compared to national data. Specialty MCPs' satisfaction survey results showed that overall, their Medi-Cal members are satisfied with the quality of services being received.

High-quality encounter data are necessary to evaluate patterns of care and services members receive, and this information can serve as a mechanism to improve quality of care. While HSAG's review of the MCPs' information systems and processes, and comparative analysis of encounter data identified opportunities for improvement, the majority of the MCPs have processes in place to submit accurate and complete encounter data to DHCS.

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

For this report, HSAG used the results from compliance review standards related to availability and accessibility of care, the MCMC 2013 access-related performance measure weighted average rates (which reflect 2012 measurement data), QIP outcome results for QIPs falling into the access domain of care, and member satisfaction survey results to assess MCMC's performance related to the access domain of care.

MCMC's compliance monitoring review findings during the review period revealed that similar to prior years, most MCPs were compliant with standards impacting access to care. The area with the most opportunity for improvement was Access and Availability of Services, and most of the findings were related to the MCPs not having policies and procedures related to access and availability standards.

In 2012, the MCMC weighted average rates for all access measures were between the MPLs and HPLs; however, in 2013, MCMC had five access measures with weighted average rates that were below the MPLs. Additionally, MCMC had seven access measures with weighted average rates that declined significantly from 2012 to 2013 compared to no access measures from 2011 to 2012. Only one access measure, *Immunizations for Adolescents—Combination 1*, had statistically significant improvement in its weighted average rate from 2012 to 2013 compared to three access measures from 2011 to 2012. The access measures with weighted average rates that declined significantly from 2012 to 2013 were:

- All four *Children and Adolescents' Access to Primary Care Practitioners* measures.
- *Cervical Cancer Screening*.
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*.
- *Prenatal and Postpartum Care—Postpartum Care*.

Five of the seven access measures with significant decline in their weighted average rates also had rates below the MPLs in 2013. As indicated above, the significant decline in the weighted average rate for the *Prenatal and Postpartum Care—Postpartum Care* measure led to the weighted average rate for this measure moving from above the MPL in 2012 to below the MPL in 2013.

HSAG cannot accurately assess if the statistically significant decline in the weighted average rates for the four *Children and Adolescents' Access to Primary Care Practitioners* measures led to the rates being below the MPLs in 2013 because 2013 was the first year the MCPs were held to the MPLs for these measures. The statistically significant decline in the other two access measures, *Cervical Cancer Screening* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* did not result in the measures' rates declining to below the MPLs.

Most MCPs' IPs for access measures with rates below the MPLs in 2012 were successful at improving the rates to above the MPLs in 2013; however, one MCP had five IPs for access measures, and none of them were successful in bringing the rates above the MPLs. As indicated above, HSAG reviewed the MCPs' IPs and found that unlike in previous years, most MCPs conducted new barrier analyses and identified new interventions for existing IPs. Additionally, most MCPs used data to drive their IPs and identified achievable outcomes. The MCPs' improvements in IP development are likely a result of MCMC implementing a more rigorous IP review and approval process and requiring MCPs to develop IPs driven by data analyses and identify interventions to address the priority barriers.

As indicated above, the overall rates for the SPD population were better than the rates for the non-SPD population for the eight *Comprehensive Diabetes Care* measures, four of which fall into the access domain of care. Also as indicated above, this is consistent with what HSAG has observed in other states and may be attributed to SPD members having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

The *All-Cause Readmissions* measure falls into the access domain of care. As indicated above, the overall rate for this measure was significantly higher for the SPD population when compared to the non-SPD population, which is also expected based on the greater and often more complicated health needs of these members. Additionally, the SPD rates in several counties for the *Children and Adolescents' Access to Primary Care Practitioners* measures, which fall into the access domain of care, were lower than the non-SPD rates. The lower rates for these measures 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. HSAG recommends that MCPs with lower SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners* measures assess the factors leading to the lower rates to ensure the needs of the SPD population are being met.

Twenty-six QIPs that progressed to the Outcomes stage fall into the access domain of care. Nineteen of the QIPs were assessed for statistically significant improvement, and only one of them achieved statistically significant improvement over baseline. Seven of the QIPs were assessed for sustained improvement, and five of them achieved sustained improvement for at least one of the study indicators. As indicated above, it appears that once statistically significant improvement is achieved, the successful improvement strategies are improved upon or maintained; however, MCPs continue to struggle with achieving the initial statistically significant improvement over baseline. While the outcomes show that QIPs are positively impacting members' access to care, there are opportunities for improvement.

The *Getting Needed Care* CAHPS measure falls into the access domain of care. Medi-Cal full-scope MCPs' CAHPS survey results showed below-average performance on this measure, with the overall MCMC rating for the adult population being *Fair* and the overall MCMC rating for the child population being *Poor* when compared to national Medicaid data. Specialty MCPs' satisfaction survey results showed that overall, their Medi-Cal members are satisfied with their access to needed health care services.

Timeliness

The timeliness domain of care relates to an MCP's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

For this report, HSAG used the results from compliance review standards related to timeliness of care, the MCMC 2013 timeliness-related performance measure weighted average rates (which reflect 2012 measurement data), QIP outcome results for QIPs falling into the timeliness domain of care, and member satisfaction survey results to assess MCMC's performance related to the timeliness domain of care.

MCMC's compliance monitoring review findings during the review period revealed that similar to prior years, MCPs were implementing utilization management programs and grievance systems supported by policies and procedures that met program requirements to facilitate timely care

decisions for beneficiaries. The findings related to utilization management were mostly related to an MCP lacking a policy or procedure or not following an established process. The findings related to the grievance system did not encompass most MCPs but were individual issues for a specific MCP and mostly were related to development and implementation of required policies and procedures.

In 2012, the MCMC weighted average rates for all timeliness measures were average. In 2013, the weighted average rates for four timeliness measures were average, and the weighted average rate for one timelines measure, *Prenatal and Postpartum Care—Postpartum Care*, declined significantly from 2012 to 2013, which resulted in the rate being below the MPL. The MCMC weighted average rate for the *Immunizations for Adolescents—Combination 1* measure, which falls into the timeliness domain of care, improved significantly from 2012 to 2013. Overall, MCMC performance on timeliness measures was average in 2013.

Most MCPs' IPs for timeliness measures with rates below the MPLs in 2012 were successful at improving the rates to above the MPLs in 2013; however, one MCP had three IPs for timeliness measures, and none of them were successful in bringing the rates above the MPLs. As indicated above, HSAG reviewed the MCPs' IPs and found, unlike in previous years, that most MCPs conducted new barrier analyses and identified new interventions for existing IPs. Additionally, most MCPs used data to drive their IPs and identified achievable outcomes. The MCPs' improvements in IP development are likely a result of MCMC implementing a more rigorous IP review and approval process and requiring MCPs to develop IPs driven by data analyses and identify interventions to address the priority barriers.

Two QIPs that progressed to the Outcomes stage fall into the timeliness domain of care. One of the QIPs was assessed for statistically significant improvement and did not achieve statistically significant improvement over baseline. The other QIP achieved sustained improvement for two of its three study indicators. As indicated above, it appears that once statistically significant improvement is achieved, the successful improvement strategies are improved upon or maintained; however, MCPs continue to struggle with achieving the initial statistically significant improvement over baseline. While the outcomes show that QIPs are positively impacting members' access to care, there are opportunities for improvement.

The *Getting Care Quickly* CAHPS measure falls into the timeliness domain of care. CAHPS survey results for full-scope MCPs showed below-average performance on this measure, with the overall MCMC rating for both the adult and child populations being *Poor* when compared to national Medicaid data. Satisfaction survey results for specialty MCPs showed that overall, their Medi-Cal members are satisfied with the timeliness of care being provided.

Conclusions

Overall, MCMC and its contracted MCPs implemented initiatives that resulted in the provision of quality, accessible, and timely health care services to MCMC beneficiaries. Taking into account MCMC's compliance monitoring review findings, MCPs were compliant with most of the elements within each of the areas reviewed. MCPs generally had appropriate resources and written policies and procedures in place to support quality improvement programs.

Most weighted averages for MCMC 2013 performance measures fell between the MPLs and HPLs, with eight measures having rates below the MPLs. Three measures had weighted average rates that improved significantly from 2012 to 2013, and nine measures had rates that declined significantly from 2012 to 2013. While some MCPs continue to struggle with improving performance on measures, most MCPs made some improvements from 2012 to 2013.

As in previous years, performance measures with the most opportunity for improvement fell primarily under the quality and access domains of care. MCMC implemented a more rigorous IP review and approval process, requiring MCPs to develop IPs driven by data analyses and identify interventions to address the priority barriers, which should increase the likelihood of the MCPs achieving statistically significant and sustained improvement on measures with below-average rates. Additionally, MCMC continued to support MCPs in selecting performance measures as formal QIPs to help structure improvement efforts and increase the likelihood of improvement.

During the review period, HSAG assessed QIPs in all three domains of care for outcomes. Results showed that, generally, once an MCP achieves statistically significant improvement, the successful improvement strategies are improved upon or maintained; however, MCPs continue to struggle with achieving the initial statistically significant improvement over baseline. While the outcomes show that QIPs are positively impacting the quality of care MCPs provided to members, there are opportunities for improvement.

Recommendations

Based on its overall assessment of MCMC in the areas of quality and timeliness of, and access to, care, HSAG provided detailed recommendations for each of the assessed activities in the activity-specific sections of this report and in the Overall Findings, Conclusions, and Recommendations Related to External Quality Review Activities section. Additionally, HSAG provided recommendations to the MCPs in their MCP-specific evaluation reports. HSAG based these recommendations on individual MCP results as they related to the quality and timeliness of, and access to, care.

HSAG will evaluate the progress made by MCMC and the MCPs with the recommendations, along with their continued successes, in the next annual review.

APPENDIX A. INDIVIDUAL MANAGED CARE PLAN PERFORMANCE MEASURE RESULTS

The following key provides definitions of symbols used in the tables on the following pages, which contain 2012 and 2013 performance measure result comparisons.

Symbol	Definition
1	DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
2	HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
3	2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
4	2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
5	Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
6	DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
7	DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡	This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
--	Indicates a new measure in 2013. The 2012 rate is not available, and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★	Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★	Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★	Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ or ▼	Statistically significant decline.
↔	No statistically significant change.
↑ or ▲	Statistically significant improvement.
NA	A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table A.1—Comparison of 2012 and 2013 Performance Measure Results
Alameda Alliance for Health—Alameda County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	31.53%	38.09%	★★★	↑	18.98%	33.33%
ACR	Q, A	--	14.66%	--	Not Comparable	--	--
AMB–ED	‡	42.02	47.24	‡	Not Comparable	‡	‡
AMB–OP	‡	315.03	297.17	‡	Not Comparable	‡	‡
CAP–1224	A	94.63%	92.32%	★	↓	95.56%	98.39%
CAP–256	A	85.48%	83.91%	★	↓	86.62%	92.63%
CAP–711	A	85.61%	85.06%	★	↔	87.56%	94.51%
CAP–1219	A	82.03%	84.64%	★	↑	86.04%	93.01%
CBP	Q	--	53.53%	--	Not Comparable	--	--
CCS	Q,A	68.37%	65.21%	★★	↔	61.81%	78.51%
CDC–BP	Q	59.85%	59.61%	★★	↔	54.48%	75.44%
CDC–E	Q,A	52.55%	48.91%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	58.88%	51.58%	★★	↓	42.09%	59.37%
CDC–H9 (>9.0%)	Q	28.47%	37.47%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	83.21%	83.45%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	43.55%	36.74%	★★	↓	28.47%	46.44%
CDC–LS	Q,A	76.89%	77.62%	★★	↔	70.34%	83.45%
CDC–N	Q,A	82.97%	82.97%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	78.10%	79.08%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	66.67%	76.40%	★★	↑	50.36%	80.91%
LBP	Q	84.76%	87.07%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	43.88%	--	Not Comparable	--	--
MMA–75	Q	--	24.23%	--	Not Comparable	--	--
MPM–ACE	Q	87.05%	84.40%	★★	↓	83.72%	91.33%
MPM–DIG	Q	86.41%	94.08%	★★	↑	87.93%	95.56%
MPM–DIU	Q	84.78%	81.92%	★	↓	83.19%	91.30%
PPC–Pre	Q,A,T	88.56%	80.54%	★★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	61.07%	57.18%	★	↔	58.70%	74.73%
W-34	Q,A,T	77.62%	71.53%	★★	↓	65.51%	83.04%
WCC–BMI	Q	55.23%	55.23%	★★	↔	29.20%	77.13%
WCC–N	Q	58.64%	64.72%	★★	↔	42.82%	77.61%
WCC–PA	Q	41.61%	46.23%	★★	↔	31.63%	64.87%

Table A.2—Comparison of 2012 and 2013 Performance Measure Results
Anthem Blue Cross Partnership Plan—Alameda County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	39.13%	42.36%	★★★	↔	18.98%	33.33%
ACR	Q, A	--	14.67%	--	Not Comparable	--	--
AMB–ED	‡	55.63	68.25	‡	Not Comparable	‡	‡
AMB–OP	‡	215.86	154.77	‡	Not Comparable	‡	‡
CAP–1224	A	93.51%	84.39%	★	↓	95.56%	98.39%
CAP–256	A	82.89%	67.77%	★	↓	86.62%	92.63%
CAP–711	A	84.12%	79.12%	★	↓	87.56%	94.51%
CAP–1219	A	79.44%	77.65%	★	↔	86.04%	93.01%
CBP	Q	--	30.66%	--	Not Comparable	--	--
CCS	Q,A	58.15%	48.13%	★	↓	61.81%	78.51%
CDC–BP	Q	47.45%	35.92%	★	↓	54.48%	75.44%
CDC–E	Q,A	35.28%	34.22%	★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	32.36%	30.58%	★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	60.58%	63.35%	★	↔	50.31%	28.95%
CDC–HT	Q,A	73.48%	63.83%	★	↓	78.54%	91.13%
CDC–LC (<100)	Q	22.38%	18.45%	★	↔	28.47%	46.44%
CDC–LS	Q,A	66.91%	55.83%	★	↓	70.34%	83.45%
CDC–N	Q,A	68.86%	71.36%	★	↔	73.48%	86.93%
CIS–3	Q,A,T	70.56%	71.29%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	64.96%	73.16%	★★	↑	50.36%	80.91%
LBP	Q	91.46%	90.20%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	42.61%	--	Not Comparable	--	--
MMA–75	Q	--	20.87%	--	Not Comparable	--	--
MPM–ACE	Q	79.35%	77.02%	★	↔	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	72.88%	73.14%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	72.99%	75.18%	★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	50.61%	36.74%	★	↓	58.70%	74.73%
W-34	Q,A,T	73.71%	57.32%	★	↓	65.51%	83.04%
WCC–BMI	Q	44.04%	62.29%	★★	↑	29.20%	77.13%
WCC–N	Q	62.04%	61.07%	★★	↔	42.82%	77.61%
WCC–PA	Q	31.14%	37.47%	★★	↔	31.63%	64.87%

Table A.3—Comparison of 2012 and 2013 Performance Measure Results
Anthem Blue Cross Partnership Plan—Contra Costa County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	NA	54.29%	★★★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	18.62%	--	Not Comparable	--	--
AMB–ED	‡	52.20	61.62	‡	Not Comparable	‡	‡
AMB–OP	‡	213.84	202.66	‡	Not Comparable	‡	‡
CAP–1224	A	93.04%	96.93%	★★	↑	95.56%	98.39%
CAP–256	A	82.73%	85.01%	★	↑	86.62%	92.63%
CAP–711	A	80.01%	85.18%	★	↑	87.56%	94.51%
CAP–1219	A	80.28%	82.76%	★	↔	86.04%	93.01%
CBP	Q	--	46.15%	--	Not Comparable	--	--
CCS	Q,A	58.15%	57.11%	★	↔	61.81%	78.51%
CDC–BP	Q	46.72%	50.99%	★	↔	54.48%	75.44%
CDC–E	Q,A	36.50%	38.61%	★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	29.20%	39.60%	★	↑	42.09%	59.37%
CDC–H9 (>9.0%)	Q	65.69%	52.97%	★	▲	50.31%	28.95%
CDC–HT	Q,A	67.15%	69.31%	★	↔	78.54%	91.13%
CDC–LC (<100)	Q	16.79%	29.21%	★★	↑	28.47%	46.44%
CDC–LS	Q,A	57.66%	64.36%	★	↔	70.34%	83.45%
CDC–N	Q,A	64.96%	67.33%	★	↔	73.48%	86.93%
CIS–3	Q,A,T	68.37%	76.16%	★★	↑	64.72%	82.48%
IMA–1	Q,A,T	65.02%	68.35%	★★	↔	50.36%	80.91%
LBP	Q	92.59%	81.48%	★★	↔	72.04%	82.04%
MMA–50	Q	--	40.34%	--	Not Comparable	--	--
MMA–75	Q	--	18.18%	--	Not Comparable	--	--
MPM–ACE	Q	76.67%	77.90%	★	↔	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	67.86%	71.53%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	76.30%	79.46%	★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	48.15%	44.64%	★	↔	58.70%	74.73%
W-34	Q,A,T	67.45%	63.93%	★	↔	65.51%	83.04%
WCC–BMI	Q	42.58%	57.66%	★★	↑	29.20%	77.13%
WCC–N	Q	53.77%	52.31%	★★	↔	42.82%	77.61%
WCC–PA	Q	25.55%	36.74%	★★	↑	31.63%	64.87%

Table A.4—Comparison of 2012 and 2013 Performance Measure Results
Anthem Blue Cross Partnership Plan—Fresno County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	29.65%	★★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	13.83%	--	Not Comparable	--	--
AMB–ED	‡	--	43.10	‡	Not Comparable	‡	‡
AMB–OP	‡	--	247.54	‡	Not Comparable	‡	‡
CAP–1224	A	--	94.35%	★	Not Comparable	95.56%	98.39%
CAP–256	A	--	82.85%	★	Not Comparable	86.62%	92.63%
CAP–711	A	--	80.34%	★	Not Comparable	87.56%	94.51%
CAP–1219	A	--	76.54%	★	Not Comparable	86.04%	93.01%
CBP	Q	--	50.85%	--	Not Comparable	--	--
CCS	Q,A	--	46.72%	★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	58.74%	★★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	38.35%	★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	41.99%	★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	50.24%	★★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	77.18%	★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	32.77%	★★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	71.84%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	77.43%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	70.80%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	70.80%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	84.06%	★★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	35.29%	--	Not Comparable	--	--
MMA–75	Q	--	14.10%	--	Not Comparable	--	--
MPM–ACE	Q	--	80.77%	★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	81.48%	★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	79.56%	★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	54.74%	★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	67.88%	★★	Not Comparable	65.51%	83.04%
WCC–BMI	Q	--	58.88%	★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	63.02%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	46.23%	★★	Not Comparable	31.63%	64.87%

Table A.5—Comparison of 2012 and 2013 Performance Measure Results
Anthem Blue Cross Partnership Plan—Kings County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	28.57%	★★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	16.58%	--	Not Comparable	--	--
AMB–ED	‡	--	68.85	‡	Not Comparable	‡	‡
AMB–OP	‡	--	368.80	‡	Not Comparable	‡	‡
CAP–1224	A	--	95.06%	★	Not Comparable	95.56%	98.39%
CAP–256	A	--	86.53%	★	Not Comparable	86.62%	92.63%
CAP–711	A	--	NA	NA	Not Comparable	87.56%	94.51%
CAP–1219	A	--	NA	NA	Not Comparable	86.04%	93.01%
CBP	Q	--	43.55%	--	Not Comparable	--	--
CCS	Q,A	--	52.31%	★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	58.44%	★★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	38.31%	★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	38.64%	★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	55.19%	★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	75.00%	★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	25.97%	★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	73.05%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	73.38%	★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	66.77%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	56.12%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	76.03%	★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	NA	--	Not Comparable	--	--
MMA–75	Q	--	NA	--	Not Comparable	--	--
MPM–ACE	Q	--	85.71%	★★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	84.56%	★★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	86.11%	★★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	54.37%	★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	57.66%	★	Not Comparable	65.51%	83.04%
WCC–BMI	Q	--	46.47%	★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	44.04%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	31.39%	★	Not Comparable	31.63%	64.87%

Table A.6—Comparison of 2012 and 2013 Performance Measure Results
Anthem Blue Cross Partnership Plan—Madera County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	6.25%	★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	10.87%	--	Not Comparable	--	--
AMB–ED	‡	--	59.71	‡	Not Comparable	‡	‡
AMB–OP	‡	--	313.66	‡	Not Comparable	‡	‡
CAP–1224	A	--	97.83%	★★	Not Comparable	95.56%	98.39%
CAP–256	A	--	88.53%	★★	Not Comparable	86.62%	92.63%
CAP–711	A	--	NA	NA	Not Comparable	87.56%	94.51%
CAP–1219	A	--	NA	NA	Not Comparable	86.04%	93.01%
CBP	Q	--	53.36%	--	Not Comparable	--	--
CCS	Q,A	--	52.55%	★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	66.81%	★★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	55.02%	★★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	51.97%	★★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	36.24%	★★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	84.72%	★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	31.44%	★★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	72.93%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	79.04%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	76.40%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	67.29%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	70.10%	★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	NA	--	Not Comparable	--	--
MMA–75	Q	--	NA	--	Not Comparable	--	--
MPM–ACE	Q	--	76.60%	★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	78.26%	★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	76.10%	★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	51.57%	★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	80.29%	★★	Not Comparable	65.51%	83.04%
WCC–BMI	Q	--	77.62%	★★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	70.07%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	48.66%	★★	Not Comparable	31.63%	64.87%

Table A.7—Comparison of 2012 and 2013 Performance Measure Results
Anthem Blue Cross Partnership Plan—Sacramento County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	24.14%	31.29%	★★	↑	18.98%	33.33%
ACR	Q, A	--	12.63%	--	Not Comparable	--	--
AMB–ED	‡	41.30	53.18	‡	Not Comparable	‡	‡
AMB–OP	‡	210.80	210.46	‡	Not Comparable	‡	‡
CAP–1224	A	94.51%	93.16%	★	↓	95.56%	98.39%
CAP–256	A	81.91%	80.19%	★	↓	86.62%	92.63%
CAP–711	A	81.22%	81.14%	★	↔	87.56%	94.51%
CAP–1219	A	80.23%	80.56%	★	↔	86.04%	93.01%
CBP	Q	--	47.45%	--	Not Comparable	--	--
CCS	Q,A	58.93%	57.61%	★	↔	61.81%	78.51%
CDC–BP	Q	56.20%	57.04%	★★	↔	54.48%	75.44%
CDC–E	Q,A	32.36%	28.16%	★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	49.15%	46.12%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	42.58%	47.09%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	76.16%	75.24%	★	↔	78.54%	91.13%
CDC–LC (<100)	Q	25.79%	27.18%	★	↔	28.47%	46.44%
CDC–LS	Q,A	62.04%	67.23%	★	↔	70.34%	83.45%
CDC–N	Q,A	71.53%	71.60%	★	↔	73.48%	86.93%
CIS–3	Q,A,T	57.42%	62.77%	★	↔	64.72%	82.48%
IMA–1	Q,A,T	51.58%	61.80%	★★	↑	50.36%	80.91%
LBP	Q	84.94%	84.34%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	44.31%	--	Not Comparable	--	--
MMA–75	Q	--	21.54%	--	Not Comparable	--	--
MPM–ACE	Q	61.68%	65.15%	★	↑	83.72%	91.33%
MPM–DIG	Q	NA	86.11%	★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	61.75%	67.21%	★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	76.89%	78.73%	★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	54.26%	47.92%	★	↔	58.70%	74.73%
W-34	Q,A,T	64.33%	67.37%	★★	↔	65.51%	83.04%
WCC–BMI	Q	63.02%	65.45%	★★	↔	29.20%	77.13%
WCC–N	Q	71.29%	69.34%	★★	↔	42.82%	77.61%
WCC–PA	Q	39.42%	44.53%	★★	↔	31.63%	64.87%

Table A.8—Comparison of 2012 and 2013 Performance Measure Results
Anthem Blue Cross Partnership Plan—San Francisco County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	50.53%	53.25%	★★★	↔	18.98%	33.33%
ACR	Q, A	--	14.19%	--	Not Comparable	--	--
AMB–ED	‡	38.76	52.12	‡	Not Comparable	‡	‡
AMB–OP	‡	250.78	275.35	‡	Not Comparable	‡	‡
CAP–1224	A	95.41%	96.11%	★★	↔	95.56%	98.39%
CAP–256	A	90.78%	86.94%	★★	↓	86.62%	92.63%
CAP–711	A	91.67%	90.85%	★★	↔	87.56%	94.51%
CAP–1219	A	89.56%	89.58%	★★	↔	86.04%	93.01%
CBP	Q	--	51.82%	--	Not Comparable	--	--
CCS	Q,A	74.14%	64.80%	★★	↓	61.81%	78.51%
CDC–BP	Q	62.33%	61.80%	★★	↔	54.48%	75.44%
CDC–E	Q,A	51.63%	45.26%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	53.49%	52.55%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	33.95%	36.01%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	83.72%	86.13%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	37.67%	39.17%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	69.77%	75.91%	★★	↔	70.34%	83.45%
CDC–N	Q,A	80.00%	85.89%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	72.41%	74.68%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	69.42%	68.02%	★★	↔	50.36%	80.91%
LBP	Q	80.39%	86.73%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	38.20%	--	Not Comparable	--	--
MMA–75	Q	--	17.98%	--	Not Comparable	--	--
MPM–ACE	Q	80.10%	82.57%	★	↔	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	79.10%	81.99%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	85.71%	88.48%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	64.02%	64.85%	★★	↔	58.70%	74.73%
W-34	Q,A,T	80.00%	79.26%	★★	↔	65.51%	83.04%
WCC–BMI	Q	73.24%	60.06%	★★	↓	29.20%	77.13%
WCC–N	Q	79.32%	72.99%	★★	↓	42.82%	77.61%
WCC–PA	Q	71.78%	65.52%	★★★	↔	31.63%	64.87%

Table A.9—Comparison of 2012 and 2013 Performance Measure Results
Anthem Blue Cross Partnership Plan—San Joaquin County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	11.56%	12.33%	★	↔	18.98%	33.33%
ACR	Q, A	--	16.00%	--	Not Comparable	--	--
AMB–ED	‡	39.78	57.00	‡	Not Comparable	‡	‡
AMB–OP	‡	214.38	228.99	‡	Not Comparable	‡	‡
CAP–1224	A	90.71%	90.61%	★	↔	95.56%	98.39%
CAP–256	A	74.02%	78.63%	★	↑	86.62%	92.63%
CAP–711	A	79.97%	77.99%	★	↔	87.56%	94.51%
CAP–1219	A	77.97%	74.76%	★	↓	86.04%	93.01%
CBP	Q	--	51.34%	--	Not Comparable	--	--
CCS	Q,A	55.36%	42.51%	★	↓	61.81%	78.51%
CDC–BP	Q	61.56%	54.37%	★	↓	54.48%	75.44%
CDC–E	Q,A	36.50%	32.77%	★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	43.07%	40.53%	★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	50.12%	50.97%	★	↔	50.31%	28.95%
CDC–HT	Q,A	73.48%	69.42%	★	↔	78.54%	91.13%
CDC–LC (<100)	Q	30.66%	28.88%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	68.13%	66.26%	★	↔	70.34%	83.45%
CDC–N	Q,A	74.70%	74.76%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	67.88%	67.15%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	59.37%	63.07%	★★	↔	50.36%	80.91%
LBP	Q	78.06%	79.06%	★★	↔	72.04%	82.04%
MMA–50	Q	--	33.55%	--	Not Comparable	--	--
MMA–75	Q	--	15.79%	--	Not Comparable	--	--
MPM–ACE	Q	80.07%	71.15%	★	↓	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	79.10%	73.63%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	78.59%	70.74%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	48.18%	55.68%	★	↑	58.70%	74.73%
W-34	Q,A,T	73.83%	66.46%	★★	↓	65.51%	83.04%
WCC–BMI	Q	63.50%	62.09%	★★	↔	29.20%	77.13%
WCC–N	Q	81.51%	79.05%	★★★	↔	42.82%	77.61%
WCC–PA	Q	60.34%	61.60%	★★	↔	31.63%	64.87%

Table A.10—Comparison of 2012 and 2013 Performance Measure Results
Anthem Blue Cross Partnership Plan—Santa Clara County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	20.00%	27.20%	★★	↔	18.98%	33.33%
ACR	Q, A	--	13.74%	--	Not Comparable	--	--
AMB–ED	‡	37.89	41.51	‡	Not Comparable	‡	‡
AMB–OP	‡	232.42	254.81	‡	Not Comparable	‡	‡
CAP–1224	A	95.63%	95.81%	★★	↔	95.56%	98.39%
CAP–256	A	86.67%	87.39%	★★	↔	86.62%	92.63%
CAP–711	A	87.63%	88.05%	★★	↔	87.56%	94.51%
CAP–1219	A	86.34%	87.62%	★★	↔	86.04%	93.01%
CBP	Q	--	46.72%	--	Not Comparable	--	--
CCS	Q,A	72.24%	59.70%	★	↓	61.81%	78.51%
CDC–BP	Q	65.69%	58.50%	★★	↓	54.48%	75.44%
CDC–E	Q,A	64.48%	49.76%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	61.31%	53.88%	★★	↓	42.09%	59.37%
CDC–H9 (>9.0%)	Q	29.44%	39.08%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	85.89%	79.85%	★★	↓	78.54%	91.13%
CDC–LC (<100)	Q	47.20%	35.44%	★★	↓	28.47%	46.44%
CDC–LS	Q,A	82.73%	76.94%	★★	↓	70.34%	83.45%
CDC–N	Q,A	79.56%	80.10%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	66.91%	74.94%	★★	↑	64.72%	82.48%
IMA–1	Q,A,T	60.10%	68.86%	★★	↑	50.36%	80.91%
LBP	Q	82.43%	83.67%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	43.37%	--	Not Comparable	--	--
MMA–75	Q	--	28.11%	--	Not Comparable	--	--
MPM–ACE	Q	84.95%	86.63%	★★	↔	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	84.21%	86.61%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	79.52%	76.71%	★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	60.64%	56.20%	★	↔	58.70%	74.73%
W-34	Q,A,T	76.72%	76.72%	★★	↔	65.51%	83.04%
WCC–BMI	Q	53.28%	55.23%	★★	↔	29.20%	77.13%
WCC–N	Q	70.56%	65.94%	★★	↔	42.82%	77.61%
WCC–PA	Q	38.44%	50.36%	★★	↑	31.63%	64.87%

Table A.11—Comparison of 2012 and 2013 Performance Measure Results
Anthem Blue Cross Partnership Plan—Stanislaus County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	24.96%	22.45%	★★	↔	18.98%	33.33%
ACR	Q, A	--	14.07%	--	Not Comparable	--	--
AMB–ED	‡	55.76	62.00	‡	Not Comparable	‡	‡
AMB–OP	‡	311.24	315.94	‡	Not Comparable	‡	‡
CAP–1224	A	96.00%	96.18%	★★	↔	95.56%	98.39%
CAP–256	A	89.23%	86.34%	★	↓	86.62%	92.63%
CAP–711	A	88.47%	87.24%	★	↓	87.56%	94.51%
CAP–1219	A	85.76%	85.36%	★	↔	86.04%	93.01%
CBP	Q	--	52.07%	--	Not Comparable	--	--
CCS	Q,A	61.20%	57.14%	★	↔	61.81%	78.51%
CDC–BP	Q	65.21%	57.04%	★★	↓	54.48%	75.44%
CDC–E	Q,A	40.63%	33.25%	★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	49.64%	47.57%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	44.04%	43.69%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	76.16%	77.18%	★	↔	78.54%	91.13%
CDC–LC (<100)	Q	32.12%	31.80%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	70.56%	69.42%	★	↔	70.34%	83.45%
CDC–N	Q,A	72.75%	76.94%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	65.69%	64.72%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	54.26%	54.52%	★★	↔	50.36%	80.91%
LBP	Q	80.52%	80.27%	★★	↔	72.04%	82.04%
MMA–50	Q	--	43.67%	--	Not Comparable	--	--
MMA–75	Q	--	24.24%	--	Not Comparable	--	--
MPM–ACE	Q	83.04%	85.74%	★★	↔	83.72%	91.33%
MPM–DIG	Q	NA	90.32%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	83.22%	85.70%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	88.56%	85.19%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	56.69%	57.28%	★	↔	58.70%	74.73%
W-34	Q,A,T	64.41%	62.89%	★	↔	65.51%	83.04%
WCC–BMI	Q	49.64%	47.93%	★★	↔	29.20%	77.13%
WCC–N	Q	63.02%	53.53%	★★	↓	42.82%	77.61%
WCC–PA	Q	37.23%	43.07%	★★	↔	31.63%	64.87%

Table A.12—Comparison of 2012 and 2013 Performance Measure Results
Anthem Blue Cross Partnership Plan—Tulare County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	20.19%	19.52%	★★	↔	18.98%	33.33%
ACR	Q, A	--	11.70%	--	Not Comparable	--	--
AMB–ED	‡	25.62	42.20	‡	Not Comparable	‡	‡
AMB–OP	‡	194.99	293.82	‡	Not Comparable	‡	‡
CAP–1224	A	92.51%	92.47%	★	↔	95.56%	98.39%
CAP–256	A	71.01%	82.72%	★	↑	86.62%	92.63%
CAP–711	A	81.80%	79.60%	★	↓	87.56%	94.51%
CAP–1219	A	82.21%	82.20%	★	↔	86.04%	93.01%
CBP	Q	--	53.28%	--	Not Comparable	--	--
CCS	Q,A	68.85%	65.28%	★★	↔	61.81%	78.51%
CDC–BP	Q	68.13%	68.45%	★★	↔	54.48%	75.44%
CDC–E	Q,A	33.09%	35.68%	★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	45.26%	48.54%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	45.74%	43.69%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	77.13%	78.40%	★	↔	78.54%	91.13%
CDC–LC (<100)	Q	33.09%	32.52%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	68.61%	69.66%	★	↔	70.34%	83.45%
CDC–N	Q,A	77.62%	81.55%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	64.96%	71.78%	★★	↑	64.72%	82.48%
IMA–1	Q,A,T	57.91%	70.97%	★★	↑	50.36%	80.91%
LBP	Q	80.85%	81.07%	★★	↔	72.04%	82.04%
MMA–50	Q	--	38.07%	--	Not Comparable	--	--
MMA–75	Q	--	18.88%	--	Not Comparable	--	--
MPM–ACE	Q	70.48%	78.55%	★	↑	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	69.03%	81.57%	★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	83.07%	76.16%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	53.13%	55.96%	★	↔	58.70%	74.73%
W-34	Q,A,T	71.95%	64.91%	★	↔	65.51%	83.04%
WCC–BMI	Q	83.94%	81.51%	★★★	↔	29.20%	77.13%
WCC–N	Q	68.13%	64.23%	★★	↔	42.82%	77.61%
WCC–PA	Q	50.36%	47.93%	★★	↔	31.63%	64.87%

Table A.13—Comparison of 2012 and 2013 Performance Measure Results
CalOptima—Orange County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	20.73%	21.81%	★★	↔	18.98%	33.33%
ACR	Q, A	--	16.69%	--	Not Comparable	--	--
AMB–ED	‡	36.79	36.08	‡	Not Comparable	‡	‡
AMB–OP	‡	351.89	330.09	‡	Not Comparable	‡	‡
CAP–1224	A	97.67%	97.34%	★★	↔	95.56%	98.39%
CAP–256	A	92.55%	91.12%	★★	↓	86.62%	92.63%
CAP–711	A	92.05%	91.64%	★★	↓	87.56%	94.51%
CAP–1219	A	90.37%	90.41%	★★	↔	86.04%	93.01%
CBP	Q	--	64.64%	--	Not Comparable	--	--
CCS	Q,A	72.00%	75.07%	★★	↔	61.81%	78.51%
CDC–BP	Q	73.76%	73.95%	★★	↔	54.48%	75.44%
CDC–E	Q,A	69.25%	66.05%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	58.71%	56.98%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	30.97%	37.21%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	86.45%	82.33%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	50.75%	40.23%	★★	↓	28.47%	46.44%
CDC–LS	Q,A	85.59%	80.70%	★★	↔	70.34%	83.45%
CDC–N	Q,A	85.38%	83.02%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	81.30%	84.25%	★★★	↔	64.72%	82.48%
IMA–1	Q,A,T	69.21%	80.86%	★★	↑	50.36%	80.91%
LBP	Q	79.00%	78.34%	★★	↔	72.04%	82.04%
MMA–50	Q	--	48.71%	--	Not Comparable	--	--
MMA–75	Q	--	25.60%	--	Not Comparable	--	--
MPM–ACE	Q	90.25%	90.75%	★★	↔	83.72%	91.33%
MPM–DIG	Q	90.38%	93.54%	★★	↔	87.93%	95.56%
MPM–DIU	Q	89.29%	90.65%	★★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	84.82%	78.42%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	69.38%	63.66%	★★	↔	58.70%	74.73%
W-34	Q,A,T	82.54%	86.69%	★★★	↔	65.51%	83.04%
WCC–BMI	Q	76.92%	81.39%	★★★	↔	29.20%	77.13%
WCC–N	Q	81.43%	82.78%	★★★	↔	42.82%	77.61%
WCC–PA	Q	71.62%	75.56%	★★★	↔	31.63%	64.87%

Table A.14—Comparison of 2012 and 2013 Performance Measure Results
CalViva Health—Fresno County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	38.41%	★★★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	10.64%	--	Not Comparable	--	--
AMB–ED	‡	--	45.57	‡	Not Comparable	‡	‡
AMB–OP	‡	--	448.77	‡	Not Comparable	‡	‡
CAP–1224	A	--	97.82%	★★	Not Comparable	95.56%	98.39%
CAP–256	A	--	91.50%	★★	Not Comparable	86.62%	92.63%
CAP–711	A	--	91.74%	★★	Not Comparable	87.56%	94.51%
CAP–1219	A	--	90.68%	★★	Not Comparable	86.04%	93.01%
CBP	Q	--	58.88%	--	Not Comparable	--	--
CCS	Q,A	--	70.07%	★★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	48.66%	★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	48.91%	★★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	43.80%	★★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	47.45%	★★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	82.97%	★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	36.74%	★★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	76.64%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	75.67%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	76.89%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	76.89%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	82.11%	★★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	70.53%	--	Not Comparable	--	--
MMA–75	Q	--	43.01%	--	Not Comparable	--	--
MPM–ACE	Q	--	82.27%	★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	86.60%	★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	83.02%	★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	90.02%	★★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	63.75%	★★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	81.51%	★★	Not Comparable	65.51%	83.04%
WCC–BMI	Q	--	69.10%	★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	71.29%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	44.53%	★★	Not Comparable	31.63%	64.87%

Table A.15—Comparison of 2012 and 2013 Performance Measure Results
CalViva Health—Kings County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	32.14%	★★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	10.31%	--	Not Comparable	--	--
AMB–ED	‡	--	60.31	‡	Not Comparable	‡	‡
AMB–OP	‡	--	452.56	‡	Not Comparable	‡	‡
CAP–1224	A	--	96.98%	★★	Not Comparable	95.56%	98.39%
CAP–256	A	--	89.73%	★★	Not Comparable	86.62%	92.63%
CAP–711	A	--	NA	NA	Not Comparable	87.56%	94.51%
CAP–1219	A	--	NA	NA	Not Comparable	86.04%	93.01%
CBP	Q	--	55.23%	--	Not Comparable	--	--
CCS	Q,A	--	61.56%	★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	50.36%	★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	42.82%	★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	41.85%	★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	50.85%	★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	80.54%	★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	27.98%	★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	74.94%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	78.35%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	69.83%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	73.59%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	75.50%	★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	NA	--	Not Comparable	--	--
MMA–75	Q	--	NA	--	Not Comparable	--	--
MPM–ACE	Q	--	80.23%	★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	78.03%	★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	89.93%	★★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	57.46%	★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	67.40%	★★	Not Comparable	65.51%	83.04%
WCC–BMI	Q	--	48.42%	★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	53.28%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	41.36%	★★	Not Comparable	31.63%	64.87%

Table A.16—Comparison of 2012 and 2013 Performance Measure Results
CalViva Health—Madera County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	25.61%	★★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	10.81%	--	Not Comparable	--	--
AMB–ED	‡	--	50.89	‡	Not Comparable	‡	‡
AMB–OP	‡	--	444.01	‡	Not Comparable	‡	‡
CAP–1224	A	--	98.53%	★★★	Not Comparable	95.56%	98.39%
CAP–256	A	--	91.75%	★★	Not Comparable	86.62%	92.63%
CAP–711	A	--	NA	NA	Not Comparable	87.56%	94.51%
CAP–1219	A	--	NA	NA	Not Comparable	86.04%	93.01%
CBP	Q	--	56.69%	--	Not Comparable	--	--
CCS	Q,A	--	60.83%	★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	59.37%	★★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	55.72%	★★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	46.47%	★★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	43.31%	★★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	85.89%	★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	33.09%	★★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	70.32%	★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	81.27%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	71.29%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	65.66%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	77.17%	★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	NA	--	Not Comparable	--	--
MMA–75	Q	--	NA	--	Not Comparable	--	--
MPM–ACE	Q	--	80.80%	★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	81.88%	★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	93.35%	★★★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	65.90%	★★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	84.43%	★★★	Not Comparable	65.51%	83.04%
WCC–BMI	Q	--	62.29%	★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	73.72%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	64.72%	★★	Not Comparable	31.63%	64.87%

Table A.17—Comparison of 2012 and 2013 Performance Measure Results
Care1st Partner Plan—San Diego County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	15.38%	20.83%	★★	↔	18.98%	33.33%
ACR	Q, A	--	15.64%	--	Not Comparable	--	--
AMB–ED	‡	48.06	50.84	‡	Not Comparable	‡	‡
AMB–OP	‡	239.46	291.33	‡	Not Comparable	‡	‡
CAP–1224	A	90.56%	93.54%	★	↑	95.56%	98.39%
CAP–256	A	78.47%	82.76%	★	↑	86.62%	92.63%
CAP–711	A	81.48%	82.67%	★	↔	87.56%	94.51%
CAP–1219	A	77.75%	81.15%	★	↑	86.04%	93.01%
CBP	Q	--	51.71%	--	Not Comparable	--	--
CCS	Q,A	66.91%	47.98%	★	↓	61.81%	78.51%
CDC–BP	Q	73.90%	58.39%	★★	↓	54.48%	75.44%
CDC–E	Q,A	47.39%	40.39%	★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	49.00%	51.82%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	36.95%	42.09%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	88.76%	84.91%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	38.15%	37.23%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	81.53%	78.59%	★★	↔	70.34%	83.45%
CDC–N	Q,A	88.35%	85.40%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	73.24%	72.75%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	62.13%	70.26%	★★	↑	50.36%	80.91%
LBP	Q	82.72%	70.00%	★	↓	72.04%	82.04%
MMA–50	Q	--	40.59%	--	Not Comparable	--	--
MMA–75	Q	--	24.75%	--	Not Comparable	--	--
MPM–ACE	Q	89.19%	81.79%	★	↓	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	86.76%	80.19%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	85.00%	81.12%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	67.06%	59.18%	★★	↓	58.70%	74.73%
W-34	Q,A,T	73.44%	67.07%	★★	↔	65.51%	83.04%
WCC–BMI	Q	65.94%	74.45%	★★	↑	29.20%	77.13%
WCC–N	Q	68.37%	72.26%	★★	↔	42.82%	77.61%
WCC–PA	Q	46.72%	51.58%	★★	↔	31.63%	64.87%

Table A.18—Comparison of 2012 and 2013 Performance Measure Results
CenCal Health—San Luis Obispo County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	33.33%	14.46%	★	↓	18.98%	33.33%
ACR	Q, A	--	13.49%	--	Not Comparable	--	--
AMB–ED	‡	65.82	63.56	‡	Not Comparable	‡	‡
AMB–OP	‡	343.58	346.43	‡	Not Comparable	‡	‡
CAP–1224	A	96.17%	95.31%	★	↔	95.56%	98.39%
CAP–256	A	87.31%	86.21%	★	↔	86.62%	92.63%
CAP–711	A	88.32%	87.64%	★★	↔	87.56%	94.51%
CAP–1219	A	86.08%	86.69%	★★	↔	86.04%	93.01%
CBP	Q	--	63.02%	--	Not Comparable	--	--
CCS	Q,A	64.84%	65.00%	★★	↔	61.81%	78.51%
CDC–BP	Q	67.64%	70.56%	★★	↔	54.48%	75.44%
CDC–E	Q,A	61.56%	58.39%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	59.37%	61.31%	★★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	32.60%	31.14%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	81.02%	82.00%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	41.36%	42.58%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	78.59%	79.56%	★★	↔	70.34%	83.45%
CDC–N	Q,A	84.67%	82.73%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	76.39%	78.03%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	60.10%	71.65%	★★	↑	50.36%	80.91%
LBP	Q	77.86%	75.69%	★★	↔	72.04%	82.04%
MMA–50	Q	--	42.34%	--	Not Comparable	--	--
MMA–75	Q	--	26.28%	--	Not Comparable	--	--
MPM–ACE	Q	82.95%	81.02%	★	↔	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	82.35%	84.20%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	82.76%	87.43%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	70.11%	71.04%	★★	↔	58.70%	74.73%
W-34	Q,A,T	69.79%	67.97%	★★	↔	65.51%	83.04%
WCC–BMI	Q	62.29%	64.23%	★★	↔	29.20%	77.13%
WCC–N	Q	59.61%	61.31%	★★	↔	42.82%	77.61%
WCC–PA	Q	47.69%	50.36%	★★	↔	31.63%	64.87%

Table A.19—Comparison of 2012 and 2013 Performance Measure Results CenCal Health—Santa Barbara County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	29.55%	19.13%	★★	↓	18.98%	33.33%
ACR	Q, A	--	11.13%	--	Not Comparable	--	--
AMB–ED	‡	48.37	52.16	‡	Not Comparable	‡	‡
AMB–OP	‡	346.64	335.52	‡	Not Comparable	‡	‡
CAP–1224	A	97.31%	97.84%	★★	↔	95.56%	98.39%
CAP–256	A	90.42%	91.16%	★★	↔	86.62%	92.63%
CAP–711	A	89.69%	90.88%	★★	↑	87.56%	94.51%
CAP–1219	A	87.69%	89.29%	★★	↑	86.04%	93.01%
CBP	Q	--	60.58%	--	Not Comparable	--	--
CCS	Q,A	71.65%	72.51%	★★	↔	61.81%	78.51%
CDC–BP	Q	69.10%	74.21%	★★	↔	54.48%	75.44%
CDC–E	Q,A	71.29%	70.56%	★★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	69.34%	59.61%	★★★	↓	42.09%	59.37%
CDC–H9 (>9.0%)	Q	22.63%	33.58%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	92.21%	83.94%	★★	↓	78.54%	91.13%
CDC–LC (<100)	Q	50.12%	38.93%	★★	↓	28.47%	46.44%
CDC–LS	Q,A	85.16%	80.54%	★★	↔	70.34%	83.45%
CDC–N	Q,A	87.35%	82.48%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	85.20%	85.84%	★★★	↔	64.72%	82.48%
IMA–1	Q,A,T	70.07%	78.74%	★★	↑	50.36%	80.91%
LBP	Q	80.46%	80.57%	★★	↔	72.04%	82.04%
MMA–50	Q	--	47.38%	--	Not Comparable	--	--
MMA–75	Q	--	27.67%	--	Not Comparable	--	--
MPM–ACE	Q	86.89%	84.72%	★★	↔	83.72%	91.33%
MPM–DIG	Q	NA	86.11%	★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	87.25%	85.46%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	80.74%	81.64%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	76.35%	73.44%	★★	↔	58.70%	74.73%
W-34	Q,A,T	76.01%	79.34%	★★	↔	65.51%	83.04%
WCC–BMI	Q	66.42%	70.56%	★★	↔	29.20%	77.13%
WCC–N	Q	67.88%	72.75%	★★	↔	42.82%	77.61%
WCC–PA	Q	44.77%	51.34%	★★	↔	31.63%	64.87%

Table A.20—Comparison of 2012 and 2013 Performance Measure Results
Central California Alliance for Health—Merced County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	11.61%	16.23%	★	↑	18.98%	33.33%
ACR	Q, A	--	12.73%	--	Not Comparable	--	--
AMB–ED	‡	49.09	53.69	‡	Not Comparable	‡	‡
AMB–OP	‡	320.62	324.06	‡	Not Comparable	‡	‡
CAP–1224	A	96.92%	97.42%	★★	↔	95.56%	98.39%
CAP–256	A	91.25%	90.39%	★★	↓	86.62%	92.63%
CAP–711	A	89.54%	89.82%	★★	↔	87.56%	94.51%
CAP–1219	A	87.63%	90.19%	★★	↑	86.04%	93.01%
CBP	Q	--	52.80%	--	Not Comparable	--	--
CCS	Q,A	57.91%	63.77%	★★	↔	61.81%	78.51%
CDC–BP	Q	64.48%	64.96%	★★	↔	54.48%	75.44%
CDC–E	Q,A	56.20%	54.74%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	51.34%	46.72%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	37.23%	45.99%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	87.83%	84.91%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	37.96%	33.09%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	80.29%	80.54%	★★	↔	70.34%	83.45%
CDC–N	Q,A	82.48%	84.91%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	64.72%	64.74%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	50.12%	55.96%	★★	↔	50.36%	80.91%
LBP	Q	84.15%	79.33%	★★	↓	72.04%	82.04%
MMA–50	Q	--	48.30%	--	Not Comparable	--	--
MMA–75	Q	--	26.16%	--	Not Comparable	--	--
MPM–ACE	Q	86.41%	87.14%	★★	↔	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	87.31%	86.97%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	85.40%	83.92%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	59.61%	58.79%	★★	↔	58.70%	74.73%
W-34	Q,A,T	72.51%	74.33%	★★	↔	65.51%	83.04%
WCC–BMI	Q	58.88%	77.62%	★★★	↑	29.20%	77.13%
WCC–N	Q	64.23%	66.91%	★★	↔	42.82%	77.61%
WCC–PA	Q	44.28%	44.77%	★★	↔	31.63%	64.87%

Table A.21—Comparison of 2012 and 2013 Performance Measure Results
Central California Alliance for Health—Monterey/Santa Cruz Counties

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	27.95%	22.27%	★★	↓	18.98%	33.33%
ACR	Q, A	--	12.06%	--	Not Comparable	--	--
AMB–ED	‡	51.95	52.10	‡	Not Comparable	‡	‡
AMB–OP	‡	320.58	318.74	‡	Not Comparable	‡	‡
CAP–1224	A	97.42%	98.49%	★★★	↑	95.56%	98.39%
CAP–256	A	91.05%	91.29%	★★	↔	86.62%	92.63%
CAP–711	A	89.57%	90.89%	★★	↑	87.56%	94.51%
CAP–1219	A	88.93%	91.00%	★★	↑	86.04%	93.01%
CBP	Q	--	55.96%	--	Not Comparable	--	--
CCS	Q,A	73.24%	71.65%	★★	↔	61.81%	78.51%
CDC–BP	Q	76.64%	71.05%	★★	↔	54.48%	75.44%
CDC–E	Q,A	67.40%	63.02%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	61.80%	51.09%	★★	↓	42.09%	59.37%
CDC–H9 (>9.0%)	Q	28.22%	36.98%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	91.97%	87.35%	★★	↓	78.54%	91.13%
CDC–LC (<100)	Q	47.20%	39.66%	★★	↓	28.47%	46.44%
CDC–LS	Q,A	84.91%	78.83%	★★	↓	70.34%	83.45%
CDC–N	Q,A	79.81%	79.32%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	84.18%	83.84%	★★★	↔	64.72%	82.48%
IMA–1	Q,A,T	63.99%	77.60%	★★	↑	50.36%	80.91%
LBP	Q	85.12%	88.00%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	49.96%	--	Not Comparable	--	--
MMA–75	Q	--	24.42%	--	Not Comparable	--	--
MPM–ACE	Q	88.31%	85.86%	★★	↓	83.72%	91.33%
MPM–DIG	Q	87.93%	89.47%	★★	↔	87.93%	95.56%
MPM–DIU	Q	88.95%	85.58%	★★	↓	83.19%	91.30%
PPC–Pre	Q,A,T	86.13%	81.76%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	77.62%	70.27%	★★	↓	58.70%	74.73%
W-34	Q,A,T	83.21%	82.08%	★★	↔	65.51%	83.04%
WCC–BMI	Q	79.08%	81.89%	★★★	↔	29.20%	77.13%
WCC–N	Q	80.29%	81.63%	★★★	↔	42.82%	77.61%
WCC–PA	Q	61.31%	66.58%	★★★	↔	31.63%	64.87%

Table A.22—Comparison of 2012 and 2013 Performance Measure Results
Community Health Group Partnership Plan—San Diego County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	14.08%	32.02%	★★	↑	18.98%	33.33%
ACR	Q, A	--	14.37%	--	Not Comparable	--	--
AMB–ED	‡	32.73	37.42	‡	Not Comparable	‡	‡
AMB–OP	‡	329.00	310.89	‡	Not Comparable	‡	‡
CAP–1224	A	96.21%	97.32%	★★	↑	95.56%	98.39%
CAP–256	A	90.27%	89.85%	★★	↔	86.62%	92.63%
CAP–711	A	89.61%	89.90%	★★	↔	87.56%	94.51%
CAP–1219	A	88.45%	88.64%	★★	↔	86.04%	93.01%
CBP	Q	--	52.07%	--	Not Comparable	--	--
CCS	Q,A	69.10%	69.59%	★★	↔	61.81%	78.51%
CDC–BP	Q	57.18%	64.72%	★★	↑	54.48%	75.44%
CDC–E	Q,A	53.28%	55.47%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	47.69%	56.45%	★★	↑	42.09%	59.37%
CDC–H9 (>9.0%)	Q	43.80%	34.31%	★★	▲	50.31%	28.95%
CDC–HT	Q,A	87.35%	90.02%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	35.04%	39.66%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	82.24%	83.70%	★★★	↔	70.34%	83.45%
CDC–N	Q,A	79.08%	83.21%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	73.97%	73.97%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	73.48%	79.32%	★★	↑	50.36%	80.91%
LBP	Q	75.03%	79.24%	★★	↑	72.04%	82.04%
MMA–50	Q	--	35.41%	--	Not Comparable	--	--
MMA–75	Q	--	18.66%	--	Not Comparable	--	--
MPM–ACE	Q	87.07%	84.99%	★★	↓	83.72%	91.33%
MPM–DIG	Q	NA	91.23%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	85.01%	85.04%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	77.86%	82.24%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	60.10%	55.23%	★	↔	58.70%	74.73%
W-34	Q,A,T	77.13%	77.86%	★★	↔	65.51%	83.04%
WCC–BMI	Q	73.48%	78.10%	★★★	↔	29.20%	77.13%
WCC–N	Q	71.53%	71.29%	★★	↔	42.82%	77.61%
WCC–PA	Q	55.96%	63.99%	★★	↑	31.63%	64.87%

Table A.23—Comparison of 2012 and 2013 Performance Measure Results
Contra Costa Health Plan—Contra Costa County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	26.52%	43.27%	★★★	↑	18.98%	33.33%
ACR	Q, A	--	16.99%	--	Not Comparable	--	--
AMB–ED	‡	59.47	60.94	‡	Not Comparable	‡	‡
AMB–OP	‡	274.88	217.23	‡	Not Comparable	‡	‡
CAP–1224	A	93.97%	86.74%	★	↓	95.56%	98.39%
CAP–256	A	84.54%	76.18%	★	↓	86.62%	92.63%
CAP–711	A	84.07%	77.96%	★	↓	87.56%	94.51%
CAP–1219	A	83.25%	74.86%	★	↓	86.04%	93.01%
CBP	Q	--	51.34%	--	Not Comparable	--	--
CCS	Q,A	66.67%	66.04%	★★	↔	61.81%	78.51%
CDC–BP	Q	54.99%	59.37%	★★	↔	54.48%	75.44%
CDC–E	Q,A	52.80%	51.09%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	53.04%	49.88%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	36.98%	40.39%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	84.91%	85.40%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	36.25%	41.61%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	75.43%	82.00%	★★	↑	70.34%	83.45%
CDC–N	Q,A	87.35%	82.00%	★★	↓	73.48%	86.93%
CIS–3	Q,A,T	85.40%	84.47%	★★★	↔	64.72%	82.48%
IMA–1	Q,A,T	59.85%	71.61%	★★	↑	50.36%	80.91%
LBP	Q	88.58%	92.06%	★★★	↑	72.04%	82.04%
MMA–50	Q	--	56.90%	--	Not Comparable	--	--
MMA–75	Q	--	33.95%	--	Not Comparable	--	--
MPM–ACE	Q	85.62%	83.77%	★★	↔	83.72%	91.33%
MPM–DIG	Q	NA	85.71%	★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	80.95%	83.68%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	83.21%	86.86%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	64.96%	62.53%	★★	↔	58.70%	74.73%
W-34	Q,A,T	77.86%	73.31%	★★	↔	65.51%	83.04%
WCC–BMI	Q	59.37%	56.20%	★★	↔	29.20%	77.13%
WCC–N	Q	55.72%	55.96%	★★	↔	42.82%	77.61%
WCC–PA	Q	46.47%	46.23%	★★	↔	31.63%	64.87%

Table A.24—Comparison of 2012 and 2013 Performance Measure Results
Gold Coast Health Plan—Ventura County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	13.87%	★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	19.17%	--	Not Comparable	--	--
AMB–ED	‡	--	49.21	‡	Not Comparable	‡	‡
AMB–OP	‡	--	317.16	‡	Not Comparable	‡	‡
CAP–1224	A	--	82.51%	★	Not Comparable	95.56%	98.39%
CAP–256	A	--	63.09%	★	Not Comparable	86.62%	92.63%
CAP–711	A	--	NA	NA	Not Comparable	87.56%	94.51%
CAP–1219	A	--	NA	NA	Not Comparable	86.04%	93.01%
CBP	Q	--	61.56%	--	Not Comparable	--	--
CCS	Q,A	--	57.66%	★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	62.29%	★★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	42.58%	★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	37.96%	★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	56.20%	★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	81.75%	★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	33.58%	★★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	78.83%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	79.81%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	80.05%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	65.21%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	76.95%	★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	NA	--	Not Comparable	--	--
MMA–75	Q	--	NA	--	Not Comparable	--	--
MPM–ACE	Q	--	86.73%	★★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	88.46%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	86.28%	★★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	80.78%	★★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	63.99%	★★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	61.80%	★	Not Comparable	65.51%	83.04%
WCC–BMI	Q	--	42.09%	★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	42.09%	★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	30.41%	★	Not Comparable	31.63%	64.87%

Table A.25—Comparison of 2012 and 2013 Performance Measure Results
Health Net Community Solutions, Inc.—Kern County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	17.23%	26.00%	★★	↑	18.98%	33.33%
ACR	Q, A	--	10.40%	--	Not Comparable	--	--
AMB–ED	‡	47.52	53.28	‡	Not Comparable	‡	‡
AMB–OP	‡	269.41	200.09	‡	Not Comparable	‡	‡
CAP–1224	A	93.78%	89.78%	★	↓	95.56%	98.39%
CAP–256	A	80.79%	70.48%	★	↓	86.62%	92.63%
CAP–711	A	78.17%	68.16%	★	↓	87.56%	94.51%
CAP–1219	A	81.18%	76.57%	★	↓	86.04%	93.01%
CBP	Q	--	51.34%	--	Not Comparable	--	--
CCS	Q,A	67.16%	46.99%	★	↓	61.81%	78.51%
CDC–BP	Q	65.82%	50.12%	★	↓	54.48%	75.44%
CDC–E	Q,A	54.04%	44.28%	★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	40.88%	38.20%	★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	50.58%	52.80%	★	↔	50.31%	28.95%
CDC–HT	Q,A	78.52%	73.24%	★	↔	78.54%	91.13%
CDC–LC (<100)	Q	35.57%	38.93%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	73.21%	72.75%	★★	↔	70.34%	83.45%
CDC–N	Q,A	83.14%	80.78%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	71.35%	68.71%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	60.58%	71.90%	★★	↑	50.36%	80.91%
LBP	Q	75.26%	73.53%	★★	↔	72.04%	82.04%
MMA–50	Q	--	69.12%	--	Not Comparable	--	--
MMA–75	Q	--	51.47%	--	Not Comparable	--	--
MPM–ACE	Q	77.67%	75.85%	★	↔	83.72%	91.33%
MPM–DIG	Q	NA	83.33%	★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	79.57%	76.59%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	89.47%	78.87%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	62.41%	53.09%	★	↓	58.70%	74.73%
W-34	Q,A,T	69.21%	65.54%	★★	↔	65.51%	83.04%
WCC–BMI	Q	55.28%	72.02%	★★	↑	29.20%	77.13%
WCC–N	Q	71.24%	81.02%	★★★	↑	42.82%	77.61%
WCC–PA	Q	51.24%	63.99%	★★	↑	31.63%	64.87%

Table A.26—Comparison of 2012 and 2013 Performance Measure Results
Health Net Community Solutions, Inc.—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	21.40%	40.16%	★★★	↑	18.98%	33.33%
ACR	Q, A	--	11.93%	--	Not Comparable	--	--
AMB–ED	‡	33.03	36.51	‡	Not Comparable	‡	‡
AMB–OP	‡	241.22	251.36	‡	Not Comparable	‡	‡
CAP–1224	A	96.13%	94.29%	★	↓	95.56%	98.39%
CAP–256	A	88.17%	81.11%	★	↓	86.62%	92.63%
CAP–711	A	87.98%	83.12%	★	↓	87.56%	94.51%
CAP–1219	A	85.90%	82.82%	★	↓	86.04%	93.01%
CBP	Q	--	57.91%	--	Not Comparable	--	--
CCS	Q,A	68.41%	63.06%	★★	↔	61.81%	78.51%
CDC–BP	Q	67.53%	50.12%	★	↓	54.48%	75.44%
CDC–E	Q,A	58.82%	47.69%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	48.47%	39.90%	★	↓	42.09%	59.37%
CDC–H9 (>9.0%)	Q	39.76%	48.42%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	83.53%	78.10%	★	↓	78.54%	91.13%
CDC–LC (<100)	Q	37.41%	35.52%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	76.47%	75.43%	★★	↔	70.34%	83.45%
CDC–N	Q,A	82.35%	82.97%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	87.62%	81.63%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	65.02%	73.67%	★★	↑	50.36%	80.91%
LBP	Q	81.09%	78.01%	★★	↓	72.04%	82.04%
MMA–50	Q	--	72.65%	--	Not Comparable	--	--
MMA–75	Q	--	49.52%	--	Not Comparable	--	--
MPM–ACE	Q	74.03%	76.09%	★	↑	83.72%	91.33%
MPM–DIG	Q	76.99%	85.92%	★	↑	87.93%	95.56%
MPM–DIU	Q	74.07%	76.27%	★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	83.64%	73.41%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	52.34%	48.05%	★	↔	58.70%	74.73%
W-34	Q,A,T	83.10%	77.08%	★★	↔	65.51%	83.04%
WCC–BMI	Q	71.53%	75.78%	★★	↔	29.20%	77.13%
WCC–N	Q	79.86%	80.73%	★★★	↔	42.82%	77.61%
WCC–PA	Q	63.66%	66.41%	★★★	↔	31.63%	64.87%

Table A.27—Comparison of 2012 and 2013 Performance Measure Results
Health Net Community Solutions, Inc.—Sacramento County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	20.21%	51.66%	★★★	↑	18.98%	33.33%
ACR	Q, A	--	12.15%	--	Not Comparable	--	--
AMB–ED	‡	38.10	45.02	‡	Not Comparable	‡	‡
AMB–OP	‡	241.00	300.55	‡	Not Comparable	‡	‡
CAP–1224	A	95.41%	92.53%	★	↓	95.56%	98.39%
CAP–256	A	84.73%	80.19%	★	↓	86.62%	92.63%
CAP–711	A	84.22%	80.69%	★	↓	87.56%	94.51%
CAP–1219	A	83.57%	81.64%	★	↓	86.04%	93.01%
CBP	Q	--	54.50%	--	Not Comparable	--	--
CCS	Q,A	69.34%	53.95%	★	↓	61.81%	78.51%
CDC–BP	Q	62.91%	48.91%	★	↓	54.48%	75.44%
CDC–E	Q,A	48.36%	40.63%	★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	52.82%	43.55%	★★	↓	42.09%	59.37%
CDC–H9 (>9.0%)	Q	35.92%	45.26%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	83.57%	77.86%	★	↓	78.54%	91.13%
CDC–LC (<100)	Q	33.57%	35.77%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	73.94%	67.40%	★	↓	70.34%	83.45%
CDC–N	Q,A	82.63%	83.45%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	69.55%	66.67%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	54.61%	63.08%	★★	↑	50.36%	80.91%
LBP	Q	87.52%	87.00%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	78.74%	--	Not Comparable	--	--
MMA–75	Q	--	55.94%	--	Not Comparable	--	--
MPM–ACE	Q	59.33%	67.16%	★	↑	83.72%	91.33%
MPM–DIG	Q	NA	82.46%	★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	55.59%	67.40%	★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	83.58%	81.77%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	60.78%	53.16%	★	↓	58.70%	74.73%
W-34	Q,A,T	78.20%	71.18%	★★	↔	65.51%	83.04%
WCC–BMI	Q	69.51%	77.32%	★★★	↑	29.20%	77.13%
WCC–N	Q	77.58%	76.34%	★★	↔	42.82%	77.61%
WCC–PA	Q	52.69%	57.07%	★★	↔	31.63%	64.87%

Table A.28—Comparison of 2012 and 2013 Performance Measure Results
Health Net Community Solutions, Inc.—San Diego County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	18.46%	44.85%	★★★	↑	18.98%	33.33%
ACR	Q, A	--	15.96%	--	Not Comparable	--	--
AMB–ED	‡	44.10	50.92	‡	Not Comparable	‡	‡
AMB–OP	‡	258.60	317.66	‡	Not Comparable	‡	‡
CAP–1224	A	94.01%	93.98%	★	↔	95.56%	98.39%
CAP–256	A	85.83%	85.27%	★	↔	86.62%	92.63%
CAP–711	A	85.38%	84.91%	★	↔	87.56%	94.51%
CAP–1219	A	82.99%	82.51%	★	↔	86.04%	93.01%
CBP	Q	--	55.23%	--	Not Comparable	--	--
CCS	Q,A	66.28%	51.75%	★	↓	61.81%	78.51%
CDC–BP	Q	64.38%	52.07%	★	↓	54.48%	75.44%
CDC–E	Q,A	51.91%	45.99%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	48.35%	50.85%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	41.48%	41.61%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	84.48%	85.40%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	35.62%	41.12%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	76.34%	79.08%	★★	↔	70.34%	83.45%
CDC–N	Q,A	78.63%	82.24%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	77.30%	72.30%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	65.29%	76.86%	★★	↑	50.36%	80.91%
LBP	Q	77.40%	76.04%	★★	↔	72.04%	82.04%
MMA–50	Q	--	75.28%	--	Not Comparable	--	--
MMA–75	Q	--	55.06%	--	Not Comparable	--	--
MPM–ACE	Q	78.12%	83.68%	★	↑	83.72%	91.33%
MPM–DIG	Q	NA	100.0%	★★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	77.56%	83.82%	★★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	83.38%	76.67%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	54.77%	53.75%	★	↔	58.70%	74.73%
W-34	Q,A,T	70.00%	74.43%	★★	↔	65.51%	83.04%
WCC–BMI	Q	67.56%	72.99%	★★	↔	29.20%	77.13%
WCC–N	Q	67.78%	74.70%	★★	↑	42.82%	77.61%
WCC–PA	Q	49.56%	67.15%	★★★	↑	31.63%	64.87%

**Table A.29—Comparison of 2012 and 2013 Performance Measure Results
Health Net Community Solutions, Inc.—Stanislaus County**

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	29.55%	32.31%	★★	↔	18.98%	33.33%
ACR	Q, A	--	8.71%	--	Not Comparable	--	--
AMB–ED	‡	49.38	55.13	‡	Not Comparable	‡	‡
AMB–OP	‡	349.91	369.94	‡	Not Comparable	‡	‡
CAP–1224	A	97.18%	97.04%	★★	↔	95.56%	98.39%
CAP–256	A	88.90%	87.15%	★★	↓	86.62%	92.63%
CAP–711	A	87.88%	85.24%	★	↓	87.56%	94.51%
CAP–1219	A	85.93%	86.00%	★	↔	86.04%	93.01%
CBP	Q	--	56.20%	--	Not Comparable	--	--
CCS	Q,A	77.28%	59.12%	★	↓	61.81%	78.51%
CDC–BP	Q	67.30%	58.39%	★★	↓	54.48%	75.44%
CDC–E	Q,A	50.00%	41.61%	★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	53.08%	56.93%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	36.49%	31.87%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	84.60%	88.32%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	39.34%	34.55%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	76.07%	78.59%	★★	↔	70.34%	83.45%
CDC–N	Q,A	77.01%	78.59%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	68.52%	71.67%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	54.18%	65.77%	★★	↑	50.36%	80.91%
LBP	Q	83.83%	83.22%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	77.04%	--	Not Comparable	--	--
MMA–75	Q	--	52.55%	--	Not Comparable	--	--
MPM–ACE	Q	75.91%	83.73%	★★	↑	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	79.78%	84.46%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	91.52%	91.90%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	60.10%	58.73%	★★	↔	58.70%	74.73%
W-34	Q,A,T	71.11%	70.47%	★★	↔	65.51%	83.04%
WCC–BMI	Q	58.68%	70.56%	★★	↑	29.20%	77.13%
WCC–N	Q	65.75%	65.69%	★★	↔	42.82%	77.61%
WCC–PA	Q	40.18%	58.15%	★★	↑	31.63%	64.87%

Table A.30—Comparison of 2012 and 2013 Performance Measure Results
Health Net Community Solutions, Inc.—Tulare County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	22.85%	26.14%	★★	↔	18.98%	33.33%
ACR	Q, A	--	11.86%	--	Not Comparable	--	--
AMB–ED	‡	39.30	41.73	‡	Not Comparable	‡	‡
AMB–OP	‡	386.74	467.09	‡	Not Comparable	‡	‡
CAP–1224	A	97.32%	97.76%	★★	↔	95.56%	98.39%
CAP–256	A	92.25%	92.37%	★★	↔	86.62%	92.63%
CAP–711	A	92.76%	91.72%	★★	↔	87.56%	94.51%
CAP–1219	A	91.48%	93.05%	★★★	↑	86.04%	93.01%
CBP	Q	--	54.01%	--	Not Comparable	--	--
CCS	Q,A	78.83%	63.54%	★★	↓	61.81%	78.51%
CDC–BP	Q	67.45%	54.26%	★	↓	54.48%	75.44%
CDC–E	Q,A	56.84%	41.85%	★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	47.88%	49.64%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	43.40%	43.55%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	83.02%	86.62%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	36.56%	36.50%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	76.18%	77.86%	★★	↔	70.34%	83.45%
CDC–N	Q,A	82.78%	82.00%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	78.93%	78.47%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	61.80%	78.32%	★★	↑	50.36%	80.91%
LBP	Q	82.72%	80.00%	★★	↔	72.04%	82.04%
MMA–50	Q	--	72.85%	--	Not Comparable	--	--
MMA–75	Q	--	47.68%	--	Not Comparable	--	--
MPM–ACE	Q	83.59%	83.50%	★	↔	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	79.73%	84.60%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	93.75%	90.16%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	67.93%	65.57%	★★	↔	58.70%	74.73%
W-34	Q,A,T	77.32%	73.31%	★★	↔	65.51%	83.04%
WCC–BMI	Q	77.57%	76.64%	★★	↔	29.20%	77.13%
WCC–N	Q	66.36%	66.42%	★★	↔	42.82%	77.61%
WCC–PA	Q	45.33%	49.15%	★★	↔	31.63%	64.87%

Table A.31—Comparison of 2012 and 2013 Performance Measure Results
Health Plan of San Joaquin—San Joaquin County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	25.42%	29.24%	★★	↔	18.98%	33.33%
ACR	Q, A	--	7.07%	--	Not Comparable	--	--
AMB–ED	‡	38.16	46.68	‡	Not Comparable	‡	‡
AMB–OP	‡	283.73	274.87	‡	Not Comparable	‡	‡
CAP–1224	A	96.66%	97.49%	★★	↑	95.56%	98.39%
CAP–256	A	86.82%	87.59%	★★	↑	86.62%	92.63%
CAP–711	A	84.17%	85.71%	★	↑	87.56%	94.51%
CAP–1219	A	83.53%	84.94%	★	↑	86.04%	93.01%
CBP	Q	--	66.42%	--	Not Comparable	--	--
CCS	Q,A	68.61%	64.23%	★★	↔	61.81%	78.51%
CDC–BP	Q	77.62%	78.28%	★★★	↔	54.48%	75.44%
CDC–E	Q,A	53.28%	45.62%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	55.96%	52.37%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	36.74%	39.60%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	81.51%	80.66%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	39.17%	35.22%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	78.59%	75.55%	★★	↔	70.34%	83.45%
CDC–N	Q,A	80.29%	82.12%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	77.13%	76.40%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	63.99%	67.15%	★★	↔	50.36%	80.91%
LBP	Q	80.67%	81.80%	★★	↔	72.04%	82.04%
MMA–50	Q	--	40.72%	--	Not Comparable	--	--
MMA–75	Q	--	21.82%	--	Not Comparable	--	--
MPM–ACE	Q	85.56%	83.69%	★	↔	83.72%	91.33%
MPM–DIG	Q	NA	92.11%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	85.05%	84.58%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	88.08%	85.64%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	68.61%	64.48%	★★	↔	58.70%	74.73%
W-34	Q,A,T	80.54%	76.16%	★★	↔	65.51%	83.04%
WCC–BMI	Q	73.48%	69.10%	★★	↔	29.20%	77.13%
WCC–N	Q	72.51%	72.75%	★★	↔	42.82%	77.61%
WCC–PA	Q	65.69%	61.80%	★★	↔	31.63%	64.87%

Table A.32—Comparison of 2012 and 2013 Performance Measure Results
Health Plan of San Mateo—San Mateo County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	34.06%	34.46%	★★★	↔	18.98%	33.33%
ACR	Q, A	--	14.52%	--	Not Comparable	--	--
AMB–ED	‡	51.62	52.11	‡	Not Comparable	‡	‡
AMB–OP	‡	483.04	546.12	‡	Not Comparable	‡	‡
CAP–1224	A	95.89%	96.70%	★★	↔	95.56%	98.39%
CAP–256	A	88.34%	88.32%	★★	↔	86.62%	92.63%
CAP–711	A	87.75%	89.36%	★★	↑	87.56%	94.51%
CAP–1219	A	84.89%	85.61%	★	↔	86.04%	93.01%
CBP	Q	--	51.34%	--	Not Comparable	--	--
CCS	Q,A	61.99%	66.33%	★★	↔	61.81%	78.51%
CDC–BP	Q	66.18%	56.93%	★★	↓	54.48%	75.44%
CDC–E	Q,A	61.07%	57.42%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	55.72%	56.45%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	37.96%	35.28%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	79.81%	83.70%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	46.47%	46.96%	★★★	↔	28.47%	46.44%
CDC–LS	Q,A	82.00%	80.78%	★★	↔	70.34%	83.45%
CDC–N	Q,A	87.83%	82.97%	★★	↓	73.48%	86.93%
CIS–3	Q,A,T	80.29%	75.56%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	68.49%	70.28%	★★	↔	50.36%	80.91%
LBP	Q	81.51%	80.07%	★★	↔	72.04%	82.04%
MMA–50	Q	--	48.51%	--	Not Comparable	--	--
MMA–75	Q	--	26.38%	--	Not Comparable	--	--
MPM–ACE	Q	89.28%	89.51%	★★	↔	83.72%	91.33%
MPM–DIG	Q	92.71%	94.95%	★★	↔	87.93%	95.56%
MPM–DIU	Q	89.85%	90.57%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	81.89%	84.18%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	61.22%	59.18%	★★	↔	58.70%	74.73%
W-34	Q,A,T	73.80%	77.13%	★★	↔	65.51%	83.04%
WCC–BMI	Q	66.67%	55.47%	★★	↓	29.20%	77.13%
WCC–N	Q	77.62%	70.05%	★★	↓	42.82%	77.61%
WCC–PA	Q	63.99%	53.91%	★★	↓	31.63%	64.87%

Table A.33—Comparison of 2012 and 2013 Performance Measure Results Inland Empire Health Plan—San Bernardino/Riverside County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	22.10%	22.53%	★★	↔	18.98%	33.33%
ACR	Q, A	--	14.24%	--	Not Comparable	--	--
AMB–ED	‡	49.54	51.67	‡	Not Comparable	‡	‡
AMB–OP	‡	326.35	347.94	‡	Not Comparable	‡	‡
CAP–1224	A	96.33%	96.75%	★★	↑	95.56%	98.39%
CAP–256	A	86.92%	86.91%	★★	↔	86.62%	92.63%
CAP–711	A	83.53%	83.18%	★	↔	87.56%	94.51%
CAP–1219	A	86.30%	86.72%	★★	↑	86.04%	93.01%
CBP	Q	--	62.91%	--	Not Comparable	--	--
CCS	Q,A	72.03%	68.53%	★★	↔	61.81%	78.51%
CDC–BP	Q	75.76%	71.00%	★★	↔	54.48%	75.44%
CDC–E	Q,A	52.68%	59.40%	★★	↑	45.03%	69.72%
CDC–H8 (<8.0%)	Q	48.72%	50.81%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	40.79%	36.19%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	82.98%	85.61%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	38.69%	42.00%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	81.12%	83.53%	★★★	↔	70.34%	83.45%
CDC–N	Q,A	83.68%	84.45%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	77.78%	78.24%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	63.66%	71.99%	★★	↑	50.36%	80.91%
LBP	Q	75.58%	77.47%	★★	↔	72.04%	82.04%
MMA–50	Q	--	44.25%	--	Not Comparable	--	--
MMA–75	Q	--	21.96%	--	Not Comparable	--	--
MPM–ACE	Q	84.22%	86.98%	★★	↑	83.72%	91.33%
MPM–DIG	Q	89.45%	91.99%	★★	↔	87.93%	95.56%
MPM–DIU	Q	83.53%	86.07%	★★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	86.42%	88.40%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	63.23%	59.63%	★★	↔	58.70%	74.73%
W-34	Q,A,T	72.19%	75.69%	★★	↔	65.51%	83.04%
WCC–BMI	Q	77.55%	78.94%	★★★	↔	29.20%	77.13%
WCC–N	Q	79.63%	74.54%	★★	↔	42.82%	77.61%
WCC–PA	Q	52.78%	47.69%	★★	↔	31.63%	64.87%

Table A.34—Comparison of 2012 and 2013 Performance Measure Results
Kaiser–Sacramento County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	47.17%	54.55%	★★★	↔	18.98%	33.33%
ACR	Q, A	--	15.71%	--	Not Comparable	--	--
AMB–ED	‡	53.84	57.00	‡	Not Comparable	‡	‡
AMB–OP	‡	413.25	410.03	‡	Not Comparable	‡	‡
CAP–1224	A	99.29%	98.38%	★★	↔	95.56%	98.39%
CAP–256	A	91.81%	90.32%	★★	↓	86.62%	92.63%
CAP–711	A	91.19%	91.82%	★★	↔	87.56%	94.51%
CAP–1219	A	92.95%	92.53%	★★	↔	86.04%	93.01%
CBP	Q	--	76.40%	--	Not Comparable	--	--
CCS	Q,A	83.91%	83.10%	★★★	↔	61.81%	78.51%
CDC–BP	Q	81.69%	79.87%	★★★	↔	54.48%	75.44%
CDC–E	Q,A	71.89%	66.16%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	61.41%	59.37%	★★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	26.06%	27.30%	★★★	↔	50.31%	28.95%
CDC–HT	Q,A	95.57%	94.09%	★★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	65.59%	66.79%	★★★	↔	28.47%	46.44%
CDC–LS	Q,A	94.29%	92.70%	★★★	↔	70.34%	83.45%
CDC–N	Q,A	89.44%	89.18%	★★★	↔	73.48%	86.93%
CIS–3	Q,A,T	82.39%	83.88%	★★★	↔	64.72%	82.48%
IMA–1	Q,A,T	80.91%	88.91%	★★★	↑	50.36%	80.91%
LBP	Q	92.05%	89.48%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	56.75%	--	Not Comparable	--	--
MMA–75	Q	--	27.16%	--	Not Comparable	--	--
MPM–ACE	Q	93.04%	94.54%	★★★	↔	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	92.53%	93.99%	★★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	93.33%	91.61%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	75.00%	75.55%	★★★	↔	58.70%	74.73%
W-34	Q,A,T	72.22%	77.88%	★★	↑	65.51%	83.04%
WCC–BMI	Q	73.52%	89.84%	★★★	↑	29.20%	77.13%
WCC–N	Q	75.92%	89.41%	★★★	↑	42.82%	77.61%
WCC–PA	Q	75.56%	89.36%	★★★	↑	31.63%	64.87%

Table A.35—Comparison of 2012 and 2013 Performance Measure Results Kaiser–San Diego County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	38.30%	NA	NA	Not Comparable	18.98%	33.33%
ACR	Q, A	--	17.51%	--	Not Comparable	--	--
AMB–ED	‡	37.16	38.94	‡	Not Comparable	‡	‡
AMB–OP	‡	478.54	479.83	‡	Not Comparable	‡	‡
CAP–1224	A	99.48%	99.52%	★★★	↔	95.56%	98.39%
CAP–256	A	94.39%	94.40%	★★★	↔	86.62%	92.63%
CAP–711	A	94.52%	95.31%	★★★	↔	87.56%	94.51%
CAP–1219	A	96.49%	96.97%	★★★	↔	86.04%	93.01%
CBP	Q	--	84.18%	--	Not Comparable	--	--
CCS	Q,A	85.04%	84.98%	★★★	↔	61.81%	78.51%
CDC–BP	Q	87.95%	85.10%	★★★	↔	54.48%	75.44%
CDC–E	Q,A	75.15%	76.07%	★★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	69.73%	69.91%	★★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	18.98%	18.34%	★★★	↔	50.31%	28.95%
CDC–HT	Q,A	96.23%	94.84%	★★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	69.43%	69.91%	★★★	↔	28.47%	46.44%
CDC–LS	Q,A	95.18%	92.84%	★★★	↔	70.34%	83.45%
CDC–N	Q,A	95.18%	93.41%	★★★	↔	73.48%	86.93%
CIS–3	Q,A,T	87.02%	87.91%	★★★	↔	64.72%	82.48%
IMA–1	Q,A,T	88.30%	89.00%	★★★	↔	50.36%	80.91%
LBP	Q	76.00%	83.03%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	61.18%	--	Not Comparable	--	--
MMA–75	Q	--	29.80%	--	Not Comparable	--	--
MPM–ACE	Q	92.20%	93.22%	★★★	↔	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	91.69%	92.74%	★★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	94.74%	91.41%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	73.21%	70.20%	★★	↔	58.70%	74.73%
W-34	Q,A,T	68.55%	70.72%	★★	↔	65.51%	83.04%
WCC–BMI	Q	97.80%	99.49%	★★★	↑	29.20%	77.13%
WCC–N	Q	65.11%	91.46%	★★★	↑	42.82%	77.61%
WCC–PA	Q	76.31%	94.11%	★★★	↑	31.63%	64.87%

Table A.36—Comparison of 2012 and 2013 Performance Measure Results
Kern Family Health Care—Kern County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	15.69%	23.02%	★★	↑	18.98%	33.33%
ACR	Q, A	--	8.77%	--	Not Comparable	--	--
AMB–ED	‡	46.64	51.02	‡	Not Comparable	‡	‡
AMB–OP	‡	282.07	255.50	‡	Not Comparable	‡	‡
CAP–1224	A	94.23%	92.37%	★	↓	95.56%	98.39%
CAP–256	A	84.12%	82.18%	★	↓	86.62%	92.63%
CAP–711	A	79.80%	79.43%	★	↔	87.56%	94.51%
CAP–1219	A	81.78%	82.20%	★	↔	86.04%	93.01%
CBP	Q	--	64.96%	--	Not Comparable	--	--
CCS	Q,A	65.69%	64.72%	★★	↔	61.81%	78.51%
CDC–BP	Q	72.81%	75.36%	★★	↔	54.48%	75.44%
CDC–E	Q,A	52.55%	45.80%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	45.26%	47.45%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	45.99%	44.53%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	82.12%	80.29%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	34.31%	33.58%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	79.38%	76.28%	★★	↔	70.34%	83.45%
CDC–N	Q,A	80.11%	77.55%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	68.61%	65.45%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	62.53%	75.67%	★★	↑	50.36%	80.91%
LBP	Q	76.45%	74.07%	★★	↔	72.04%	82.04%
MMA–50	Q	--	45.85%	--	Not Comparable	--	--
MMA–75	Q	--	21.75%	--	Not Comparable	--	--
MPM–ACE	Q	83.81%	87.71%	★★	↑	83.72%	91.33%
MPM–DIG	Q	NA	90.74%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	84.24%	87.62%	★★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	81.27%	83.70%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	60.34%	62.04%	★★	↔	58.70%	74.73%
W-34	Q,A,T	69.10%	67.64%	★★	↔	65.51%	83.04%
WCC–BMI	Q	61.80%	64.23%	★★	↔	29.20%	77.13%
WCC–N	Q	51.58%	66.42%	★★	↑	42.82%	77.61%
WCC–PA	Q	38.44%	48.91%	★★	↑	31.63%	64.87%

Table A.37—Comparison of 2012 and 2013 Performance Measure Results
L.A. Care Health Plan—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	32.31%	35.44%	★★★	↑	18.98%	33.33%
ACR	Q, A	--	17.05%	--	Not Comparable	--	--
AMB–ED	‡	31.02	32.23	‡	Not Comparable	‡	‡
AMB–OP	‡	191.44	185.93	‡	Not Comparable	‡	‡
CAP–1224	A	95.16%	91.06%	★	↓	95.56%	98.39%
CAP–256	A	86.98%	82.93%	★	↓	86.62%	92.63%
CAP–711	A	88.20%	87.15%	★	↓	87.56%	94.51%
CAP–1219	A	86.43%	85.89%	★	↓	86.04%	93.01%
CBP	Q	--	61.59%	--	Not Comparable	--	--
CCS	Q,A	72.46%	66.34%	★★	↔	61.81%	78.51%
CDC–BP	Q	64.25%	65.94%	★★	↔	54.48%	75.44%
CDC–E	Q,A	50.72%	49.76%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	42.27%	48.07%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	42.03%	39.37%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	83.82%	84.30%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	36.96%	37.68%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	79.23%	79.95%	★★	↔	70.34%	83.45%
CDC–N	Q,A	79.47%	81.64%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	81.45%	80.15%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	60.53%	72.15%	★★	↑	50.36%	80.91%
LBP	Q	81.64%	80.14%	★★	↔	72.04%	82.04%
MMA–50	Q	--	79.80%	--	Not Comparable	--	--
MMA–75	Q	--	57.70%	--	Not Comparable	--	--
MPM–ACE	Q	73.44%	73.03%	★	↔	83.72%	91.33%
MPM–DIG	Q	78.85%	78.09%	★	↔	87.93%	95.56%
MPM–DIU	Q	72.28%	72.87%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	80.63%	85.75%	★★	↑	80.54%	93.33%
PPC–Pst	Q,A,T	61.26%	55.80%	★	↔	58.70%	74.73%
W-34	Q,A,T	77.54%	72.46%	★★	↔	65.51%	83.04%
WCC–BMI	Q	64.65%	71.91%	★★	↑	29.20%	77.13%
WCC–N	Q	70.22%	74.58%	★★	↔	42.82%	77.61%
WCC–PA	Q	57.63%	67.31%	★★★	↑	31.63%	64.87%

Table A.38—Comparison of 2012 and 2013 Performance Measure Results Molina Healthcare of California Partner Plan, Inc.—Sacramento County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	28.29%	23.08%	★★	↔	18.98%	33.33%
ACR	Q, A	--	13.20%	--	Not Comparable	--	--
AMB–ED	‡	44.96	47.83	‡	Not Comparable	‡	‡
AMB–OP	‡	238.15	261.22	‡	Not Comparable	‡	‡
CAP–1224	A	95.79%	94.81%	★	↔	95.56%	98.39%
CAP–256	A	84.21%	84.09%	★	↔	86.62%	92.63%
CAP–711	A	83.45%	83.80%	★	↔	87.56%	94.51%
CAP–1219	A	83.38%	84.20%	★	↔	86.04%	93.01%
CBP	Q	--	51.29%	--	Not Comparable	--	--
CCS	Q,A	63.11%	50.51%	★	↓	61.81%	78.51%
CDC–BP	Q	58.22%	54.65%	★★	↔	54.48%	75.44%
CDC–E	Q,A	56.22%	47.91%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	46.89%	46.05%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	40.89%	43.26%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	81.78%	78.60%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	33.78%	31.63%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	69.33%	70.00%	★	↔	70.34%	83.45%
CDC–N	Q,A	83.11%	80.47%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	50.12%	54.06%	★	↔	64.72%	82.48%
IMA–1	Q,A,T	55.32%	66.04%	★★	↑	50.36%	80.91%
LBP	Q	84.03%	83.24%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	31.72%	--	Not Comparable	--	--
MMA–75	Q	--	17.24%	--	Not Comparable	--	--
MPM–ACE	Q	78.84%	73.99%	★	↓	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	74.23%	73.63%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	81.45%	69.62%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	51.36%	37.47%	★	↓	58.70%	74.73%
W-34	Q,A,T	76.10%	73.21%	★★	↔	65.51%	83.04%
WCC–BMI	Q	62.33%	54.61%	★★	↓	29.20%	77.13%
WCC–N	Q	64.65%	59.34%	★★	↔	42.82%	77.61%
WCC–PA	Q	58.37%	49.65%	★★	↓	31.63%	64.87%

Table A.39—Comparison of 2012 and 2013 Performance Measure Results Molina Healthcare of California Partner Plan, Inc.—San Bernardino/Riverside County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	20.13%	30.23%	★★	↑	18.98%	33.33%
ACR	Q, A	--	14.65%	--	Not Comparable	--	--
AMB–ED	‡	43.22	43.60	‡	Not Comparable	‡	‡
AMB–OP	‡	285.69	260.50	‡	Not Comparable	‡	‡
CAP–1224	A	94.88%	93.65%	★	↓	95.56%	98.39%
CAP–256	A	83.76%	83.03%	★	↔	86.62%	92.63%
CAP–711	A	82.68%	81.96%	★	↔	87.56%	94.51%
CAP–1219	A	84.19%	84.51%	★	↔	86.04%	93.01%
CBP	Q	--	53.83%	--	Not Comparable	--	--
CCS	Q,A	62.00%	52.75%	★	↓	61.81%	78.51%
CDC–BP	Q	59.33%	56.52%	★★	↔	54.48%	75.44%
CDC–E	Q,A	54.83%	46.68%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	40.00%	43.48%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	48.76%	43.71%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	78.65%	81.92%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	34.83%	35.93%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	77.30%	82.61%	★★	↑	70.34%	83.45%
CDC–N	Q,A	81.80%	83.30%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	59.63%	63.86%	★	↔	64.72%	82.48%
IMA–1	Q,A,T	60.88%	69.10%	★★	↑	50.36%	80.91%
LBP	Q	76.40%	78.21%	★★	↔	72.04%	82.04%
MMA–50	Q	--	31.87%	--	Not Comparable	--	--
MMA–75	Q	--	14.51%	--	Not Comparable	--	--
MPM–ACE	Q	81.55%	86.05%	★★	↑	83.72%	91.33%
MPM–DIG	Q	NA	92.11%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	81.41%	84.41%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	77.17%	64.27%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	43.84%	28.99%	★	↓	58.70%	74.73%
W-34	Q,A,T	74.77%	68.39%	★★	↔	65.51%	83.04%
WCC–BMI	Q	44.32%	42.00%	★★	↔	29.20%	77.13%
WCC–N	Q	64.97%	59.40%	★★	↔	42.82%	77.61%
WCC–PA	Q	57.08%	49.42%	★★	↓	31.63%	64.87%

Table A.40—Comparison of 2012 and 2013 Performance Measure Results
Molina Healthcare of California Partner Plan, Inc.—San Diego County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	18.21%	17.33%	★	↔	18.98%	33.33%
ACR	Q, A	--	14.45%	--	Not Comparable	--	--
AMB–ED	‡	43.30	45.58	‡	Not Comparable	‡	‡
AMB–OP	‡	331.91	305.90	‡	Not Comparable	‡	‡
CAP–1224	A	94.76%	95.93%	★★	↔	95.56%	98.39%
CAP–256	A	88.46%	88.02%	★★	↔	86.62%	92.63%
CAP–711	A	87.55%	88.31%	★★	↔	87.56%	94.51%
CAP–1219	A	83.75%	85.26%	★	↑	86.04%	93.01%
CBP	Q	--	52.76%	--	Not Comparable	--	--
CCS	Q,A	68.91%	59.51%	★	↓	61.81%	78.51%
CDC–BP	Q	62.00%	62.30%	★★	↔	54.48%	75.44%
CDC–E	Q,A	56.44%	58.55%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	46.22%	57.85%	★★	↑	42.09%	59.37%
CDC–H9 (>9.0%)	Q	46.67%	32.55%	★★	▲	50.31%	28.95%
CDC–HT	Q,A	84.44%	88.76%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	42.22%	47.54%	★★★	↔	28.47%	46.44%
CDC–LS	Q,A	78.22%	86.42%	★★★	↑	70.34%	83.45%
CDC–N	Q,A	80.22%	84.31%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	73.19%	75.00%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	71.30%	80.83%	★★	↑	50.36%	80.91%
LBP	Q	71.98%	72.00%	★	↔	72.04%	82.04%
MMA–50	Q	--	35.33%	--	Not Comparable	--	--
MMA–75	Q	--	18.63%	--	Not Comparable	--	--
MPM–ACE	Q	86.72%	85.15%	★★	↔	83.72%	91.33%
MPM–DIG	Q	NA	94.74%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	85.85%	86.01%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	88.94%	79.72%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	61.40%	51.52%	★	↓	58.70%	74.73%
W-34	Q,A,T	78.89%	74.74%	★★	↔	65.51%	83.04%
WCC–BMI	Q	57.67%	64.79%	★★	↑	29.20%	77.13%
WCC–N	Q	61.86%	65.96%	★★	↔	42.82%	77.61%
WCC–PA	Q	52.33%	55.16%	★★	↔	31.63%	64.87%

Table A.41—Comparison of 2012 and 2013 Performance Measure Results
Partnership HealthPlan of California—Marin County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	NA	NA	Not Comparable	18.98%	33.33%
ACR	Q, A	--	16.04%	--	Not Comparable	--	--
AMB–ED	‡	--	48.34	‡	Not Comparable	‡	‡
AMB–OP	‡	--	304.46	‡	Not Comparable	‡	‡
CAP–1224	A	--	98.76%	★★★	Not Comparable	95.56%	98.39%
CAP–256	A	--	87.69%	★★	Not Comparable	86.62%	92.63%
CAP–711	A	--	NA	NA	Not Comparable	87.56%	94.51%
CAP–1219	A	--	NA	NA	Not Comparable	86.04%	93.01%
CBP	Q	--	50.65%	--	Not Comparable	--	--
CCS	Q,A	--	64.73%	★★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	60.71%	★★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	42.46%	★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	50.40%	★★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	40.08%	★★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	87.70%	★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	34.13%	★★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	71.03%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	79.37%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	78.35%	★★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	67.47%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	85.71%	★★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	NA	--	Not Comparable	--	--
MMA–75	Q	--	NA	--	Not Comparable	--	--
MPM–ACE	Q	--	76.74%	★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	76.71%	★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	78.17%	★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	57.75%	★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	67.59%	★★	Not Comparable	65.51%	83.04%
WCC–BMI	Q	--	83.33%	★★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	63.89%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	44.44%	★★	Not Comparable	31.63%	64.87%

Table A.42—Comparison of 2012 and 2013 Performance Measure Results
Partnership HealthPlan of California—Mendocino County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	--	28.57%	★★	Not Comparable	18.98%	33.33%
ACR	Q, A	--	9.81%	--	Not Comparable	--	--
AMB–ED	‡	--	57.94	‡	Not Comparable	‡	‡
AMB–OP	‡	--	331.59	‡	Not Comparable	‡	‡
CAP–1224	A	--	95.45%	★	Not Comparable	95.56%	98.39%
CAP–256	A	--	89.15%	★★	Not Comparable	86.62%	92.63%
CAP–711	A	--	NA	NA	Not Comparable	87.56%	94.51%
CAP–1219	A	--	NA	NA	Not Comparable	86.04%	93.01%
CBP	Q	--	57.43%	--	Not Comparable	--	--
CCS	Q,A	--	58.82%	★	Not Comparable	61.81%	78.51%
CDC–BP	Q	--	57.18%	★★	Not Comparable	54.48%	75.44%
CDC–E	Q,A	--	38.86%	★	Not Comparable	45.03%	69.72%
CDC–H8 (<8.0%)	Q	--	49.75%	★★	Not Comparable	42.09%	59.37%
CDC–H9 (>9.0%)	Q	--	37.38%	★★	Not Comparable	50.31%	28.95%
CDC–HT	Q,A	--	92.82%	★★★	Not Comparable	78.54%	91.13%
CDC–LC (<100)	Q	--	37.38%	★★	Not Comparable	28.47%	46.44%
CDC–LS	Q,A	--	76.73%	★★	Not Comparable	70.34%	83.45%
CDC–N	Q,A	--	78.71%	★★	Not Comparable	73.48%	86.93%
CIS–3	Q,A,T	--	61.86%	★	Not Comparable	64.72%	82.48%
IMA–1	Q,A,T	--	51.46%	★★	Not Comparable	50.36%	80.91%
LBP	Q	--	88.05%	★★★	Not Comparable	72.04%	82.04%
MMA–50	Q	--	NA	--	Not Comparable	--	--
MMA–75	Q	--	NA	--	Not Comparable	--	--
MPM–ACE	Q	--	84.48%	★★	Not Comparable	83.72%	91.33%
MPM–DIG	Q	--	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	--	85.61%	★★	Not Comparable	83.19%	91.30%
PPC–Pre	Q,A,T	--	88.01%	★★	Not Comparable	80.54%	93.33%
PPC–Pst	Q,A,T	--	69.68%	★★	Not Comparable	58.70%	74.73%
W-34	Q,A,T	--	62.04%	★	Not Comparable	65.51%	83.04%
WCC–BMI	Q	--	69.91%	★★	Not Comparable	29.20%	77.13%
WCC–N	Q	--	55.79%	★★	Not Comparable	42.82%	77.61%
WCC–PA	Q	--	31.71%	★★	Not Comparable	31.63%	64.87%

Table A.43—Comparison of 2012 and 2013 Performance Measure Results
Partnership HealthPlan of California—Napa/Solano/Yolo Counties

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	42.76%	33.18%	★★	↓	18.98%	33.33%
ACR	Q, A	--	13.25%	--	Not Comparable	--	--
AMB–ED	‡	47.82	52.33	‡	Not Comparable	‡	‡
AMB–OP	‡	256.88	312.13	‡	Not Comparable	‡	‡
CAP–1224	A	94.91%	96.49%	★★	↑	95.56%	98.39%
CAP–256	A	82.91%	86.42%	★	↑	86.62%	92.63%
CAP–711	A	80.35%	83.67%	★	↑	87.56%	94.51%
CAP–1219	A	77.25%	84.94%	★	↑	86.04%	93.01%
CBP	Q	--	53.86%	--	Not Comparable	--	--
CCS	Q,A	65.71%	65.41%	★★	↔	61.81%	78.51%
CDC–BP	Q	69.27%	66.67%	★★	↔	54.48%	75.44%
CDC–E	Q,A	56.79%	53.42%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	60.58%	53.64%	★★	↓	42.09%	59.37%
CDC–H9 (>9.0%)	Q	28.73%	35.76%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	86.64%	85.65%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	49.22%	42.16%	★★	↓	28.47%	46.44%
CDC–LS	Q,A	78.17%	77.70%	★★	↔	70.34%	83.45%
CDC–N	Q,A	83.74%	84.33%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	71.93%	68.87%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	56.81%	65.33%	★★	↑	50.36%	80.91%
LBP	Q	88.52%	88.95%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	59.90%	--	Not Comparable	--	--
MMA–75	Q	--	39.41%	--	Not Comparable	--	--
MPM–ACE	Q	82.13%	84.46%	★★	↑	83.72%	91.33%
MPM–DIG	Q	80.88%	90.48%	★★	↔	87.93%	95.56%
MPM–DIU	Q	82.38%	82.35%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	87.27%	81.41%	★★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	70.29%	75.92%	★★★	↔	58.70%	74.73%
W-34	Q,A,T	74.34%	74.26%	★★	↔	65.51%	83.04%
WCC–BMI	Q	74.77%	77.44%	★★★	↔	29.20%	77.13%
WCC–N	Q	65.05%	67.91%	★★	↔	42.82%	77.61%
WCC–PA	Q	53.70%	52.79%	★★	↔	31.63%	64.87%

Table A.44—Comparison of 2012 and 2013 Performance Measure Results
Partnership HealthPlan of California—Sonoma County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	47.47%	27.33%	★★	↓	18.98%	33.33%
ACR	Q, A	--	13.05%	--	Not Comparable	--	--
AMB–ED	‡	43.17	44.10	‡	Not Comparable	‡	‡
AMB–OP	‡	283.01	345.59	‡	Not Comparable	‡	‡
CAP–1224	A	95.24%	96.25%	★★	↔	95.56%	98.39%
CAP–256	A	86.47%	88.58%	★★	↑	86.62%	92.63%
CAP–711	A	83.26%	85.70%	★	↑	87.56%	94.51%
CAP–1219	A	84.36%	88.23%	★★	↑	86.04%	93.01%
CBP	Q	--	54.53%	--	Not Comparable	--	--
CCS	Q,A	71.60%	70.65%	★★	↔	61.81%	78.51%
CDC–BP	Q	76.12%	69.98%	★★	↓	54.48%	75.44%
CDC–E	Q,A	54.24%	57.62%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	59.38%	51.66%	★★	↓	42.09%	59.37%
CDC–H9 (>9.0%)	Q	27.01%	34.88%	★★	▼	50.31%	28.95%
CDC–HT	Q,A	90.18%	92.27%	★★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	43.75%	39.74%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	74.33%	76.60%	★★	↔	70.34%	83.45%
CDC–N	Q,A	80.13%	80.13%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	76.62%	74.01%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	53.01%	65.66%	★★	↑	50.36%	80.91%
LBP	Q	90.42%	90.32%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	63.71%	--	Not Comparable	--	--
MMA–75	Q	--	41.62%	--	Not Comparable	--	--
MPM–ACE	Q	71.41%	69.27%	★	↔	83.72%	91.33%
MPM–DIG	Q	88.57%	85.29%	★	↔	87.93%	95.56%
MPM–DIU	Q	73.94%	72.08%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	82.96%	85.97%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	75.69%	73.73%	★★	↔	58.70%	74.73%
W-34	Q,A,T	72.16%	74.43%	★★	↔	65.51%	83.04%
WCC–BMI	Q	86.31%	87.15%	★★★	↔	29.20%	77.13%
WCC–N	Q	69.37%	68.46%	★★	↔	42.82%	77.61%
WCC–PA	Q	54.99%	51.64%	★★	↔	31.63%	64.87%

Table A.45—Comparison of 2012 and 2013 Performance Measure Results
San Francisco Health Plan—San Francisco County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	45.45%	53.75%	★★★	↔	18.98%	33.33%
ACR	Q, A	--	15.81%	--	Not Comparable	--	--
AMB–ED	‡	26.68	35.34	‡	Not Comparable	‡	‡
AMB–OP	‡	354.39	348.95	‡	Not Comparable	‡	‡
CAP–1224	A	92.98%	95.95%	★★	↑	95.56%	98.39%
CAP–256	A	87.90%	89.57%	★★	↑	86.62%	92.63%
CAP–711	A	90.08%	93.16%	★★	↑	87.56%	94.51%
CAP–1219	A	86.78%	91.13%	★★	↑	86.04%	93.01%
CBP	Q	--	66.46%	--	Not Comparable	--	--
CCS	Q,A	80.19%	76.76%	★★	↔	61.81%	78.51%
CDC–BP	Q	78.64%	74.77%	★★	↔	54.48%	75.44%
CDC–E	Q,A	69.72%	67.59%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	63.38%	62.27%	★★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	26.53%	26.39%	★★★	↔	50.31%	28.95%
CDC–HT	Q,A	91.08%	90.97%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	48.83%	47.69%	★★★	↔	28.47%	46.44%
CDC–LS	Q,A	83.33%	80.56%	★★	↔	70.34%	83.45%
CDC–N	Q,A	83.57%	87.73%	★★★	↔	73.48%	86.93%
CIS–3	Q,A,T	87.04%	85.81%	★★★	↔	64.72%	82.48%
IMA–1	Q,A,T	64.35%	81.02%	★★★	↑	50.36%	80.91%
LBP	Q	82.98%	86.53%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	42.82%	--	Not Comparable	--	--
MMA–75	Q	--	21.55%	--	Not Comparable	--	--
MPM–ACE	Q	73.20%	76.81%	★	↑	83.72%	91.33%
MPM–DIG	Q	NA	81.82%	★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	71.43%	78.74%	★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	93.44%	87.96%	★★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	75.64%	71.76%	★★	↔	58.70%	74.73%
W-34	Q,A,T	84.95%	84.26%	★★★	↔	65.51%	83.04%
WCC–BMI	Q	76.16%	85.19%	★★★	↑	29.20%	77.13%
WCC–N	Q	80.56%	85.19%	★★★	↔	42.82%	77.61%
WCC–PA	Q	72.69%	83.80%	★★★	↑	31.63%	64.87%

Table A.46—Comparison of 2012 and 2013 Performance Measure Results
Santa Clara Family Health Plan—Santa Clara County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	25.81%	26.43%	★★	↔	18.98%	33.33%
ACR	Q, A	--	13.77%	--	Not Comparable	--	--
AMB–ED	‡	35.89	34.79	‡	Not Comparable	‡	‡
AMB–OP	‡	292.77	267.45	‡	Not Comparable	‡	‡
CAP–1224	A	96.22%	96.87%	★★	↔	95.56%	98.39%
CAP–256	A	88.63%	88.90%	★★	↔	86.62%	92.63%
CAP–711	A	89.69%	88.92%	★★	↓	87.56%	94.51%
CAP–1219	A	86.78%	87.81%	★★	↑	86.04%	93.01%
CBP	Q	--	52.80%	--	Not Comparable	--	--
CCS	Q,A	71.29%	68.13%	★★	↔	61.81%	78.51%
CDC–BP	Q	45.01%	53.53%	★	↑	54.48%	75.44%
CDC–E	Q,A	47.69%	41.85%	★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	51.09%	55.47%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	40.88%	34.79%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	86.62%	86.62%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	37.96%	42.82%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	81.02%	79.08%	★★	↔	70.34%	83.45%
CDC–N	Q,A	80.05%	79.81%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	80.05%	73.72%	★★	↓	64.72%	82.48%
IMA–1	Q,A,T	69.34%	75.67%	★★	↑	50.36%	80.91%
LBP	Q	80.37%	82.42%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	58.61%	--	Not Comparable	--	--
MMA–75	Q	--	35.95%	--	Not Comparable	--	--
MPM–ACE	Q	86.05%	87.60%	★★	↔	83.72%	91.33%
MPM–DIG	Q	87.18%	88.10%	★★	↔	87.93%	95.56%
MPM–DIU	Q	84.85%	88.08%	★★	↑	83.19%	91.30%
PPC–Pre	Q,A,T	82.73%	82.97%	★★	↔	80.54%	93.33%
PPC–Pst	Q,A,T	58.39%	67.40%	★★	↑	58.70%	74.73%
W-34	Q,A,T	75.67%	72.75%	★★	↔	65.51%	83.04%
WCC–BMI	Q	64.23%	66.91%	★★	↔	29.20%	77.13%
WCC–N	Q	63.99%	67.88%	★★	↔	42.82%	77.61%
WCC–PA	Q	45.74%	41.85%	★★	↔	31.63%	64.87%

Specialty Managed Care Plans

Table A.47—Comparison of 2012 and 2013 Performance Measure Results AIDS Healthcare Foundation—Controlling High Blood Pressure

Year	2012*	2013*
Rate	**68.2%**	**62.20%**
HPL	67.6%	69.11%
MPL	47.9%	50.00%

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

Table A.48—Comparison of 2012 and 2013 Performance Measure Results AIDS Healthcare Foundation—Colorectal Cancer Screening

Year	2012**	2013
Rate	**64.2%**	**63.07%**
HPL*	74.2%	73.72%
MPL*	57.3%	55.99%

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

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

Table A.49—Comparison of 2012 and 2013 Performance Measure Results Family Mosaic Project—Inpatient Hospitalization Admissions*

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

* There is no MPL or HPL for this measure.

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

Table A.50—Comparison of 2012 and 2013 Performance Measure Results Family Mosaic Project—Out-of-Home Placements*

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

* There is no MPL or HPL for this measure.

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

Table A.51—Comparison of 2012 and 2013 Performance Measure Results
Senior Care Action Network Health Plan—Breast Cancer Screening

Year	2012*	2013
Rate	**79.9%**	**81.42%**
HPL	62.9%	62.76%
MPL	45.3%	44.82%

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

Table A.52—Comparison of 2012 and 2013 Performance Measure Results
Senior Care Action Network Health Plan
Osteoporosis Management in Women Who Had a Fracture

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

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

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

Appendix B. Individual Full-Scope Managed Care Plan SPD and Non-SPD Rates

The following key applies to the tables below, which contain 2013 performance measure comparison and results related to measures stratified by the SPD population.

Symbol	Definition
*	HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.
**	Member months are a member's "contribution" to the total yearly membership.
↑	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 from the non-SPD rates.
(▲▼)	Used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.
▼	Denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.
▲	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.

Table B.1—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Alameda Alliance for Health—Alameda County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	10.47%	15.86%	▼	14.66%
CAP–1224	92.41%	85.71%	↔	92.32%
CAP–256	83.84%	85.99%	↔	83.91%
CAP–711	85.00%	86.15%	↔	85.06%
CAP–1219	84.99%	80.59%	↓	84.64%
CDC–BP	59.37%	62.29%	↔	59.61%
CDC–E	48.91%	52.07%	↔	48.91%
CDC–H8 (<8.0%)	51.58%	53.53%	↔	51.58%
CDC–H9 (>9.0%)	37.47%	34.55%	↔	37.47%
CDC–HT	83.45%	84.43%	↔	83.45%
CDC–LC (<100)	36.74%	38.20%	↔	36.74%
CDC–LS	77.62%	78.10%	↔	77.62%
CDC–N	82.97%	83.21%	↔	82.97%
MPM–ACE	77.54%	85.99%	↑	84.40%
MPM–DIG	NA	94.30%	Not Comparable	94.08%
MPM–DIU	73.16%	84.07%	↑	81.92%

Table B.2—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Alameda Alliance for Health—Alameda County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
240.90	40.42	481.81	69.61

Table B.3—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Anthem Blue Cross Partnership Plan—Alameda County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.84%	15.98%	▼	14.67%
CAP–1224	84.31%	NA	Not Comparable	84.39%
CAP–256	67.90%	63.92%	↔	67.77%
CAP–711	78.76%	84.46%	↔	79.12%
CAP–1219	77.69%	77.30%	↔	77.65%
CDC–BP	39.62%	35.04%	↔	35.92%
CDC–E	33.46%	32.12%	↔	34.22%
CDC–H8 (<8.0%)	27.31%	31.14%	↔	30.58%
CDC–H9 (>9.0%)	65.77%	63.26%	↔	63.35%
CDC–HT	63.08%	65.45%	↔	63.83%
CDC–LC (<100)	16.92%	19.71%	↔	18.45%
CDC–LS	50.38%	55.72%	↔	55.83%
CDC–N	62.69%	76.40%	↑	71.36%
MPM–ACE	66.07%	79.85%	↑	77.02%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	62.94%	75.70%	↑	73.14%

Table B.4—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem Blue Cross Partnership Plan—Alameda County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
144.94	55.23	189.35	114.02

Table B.5—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Anthem Blue Cross Partnership Plan—Contra Costa County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	8.89%	23.00%	↔	18.62%
CAP–1224	96.88%	NA	Not Comparable	96.93%
CAP–256	84.85%	89.33%	↔	85.01%
CAP–711	85.69%	77.78%	↓	85.18%
CAP–1219	82.84%	82.10%	↔	82.76%
CDC–BP	42.68%	56.67%	↔	50.99%
CDC–E	41.46%	36.67%	↔	38.61%
CDC–H8 (<8.0%)	34.15%	43.33%	↔	39.60%
CDC–H9 (>9.0%)	60.98%	47.50%	↔	52.97%
CDC–HT	60.98%	75.00%	↑	69.31%
CDC–LC (<100)	21.95%	34.17%	↔	29.21%
CDC–LS	59.76%	67.50%	↔	64.36%
CDC–N	53.66%	76.67%	↑	67.33%
MPM–ACE	72.41%	80.49%	↔	77.90%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	58.00%	78.72%	↑	71.53%

Table B.6—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem Blue Cross Partnership Plan—Contra Costa County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
202.82	56.21	201.70	93.77

Table B.7—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Anthem Blue Cross Partnership Plan—Fresno County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	10.55%	16.79%	▼	13.83%
CAP–1224	94.28%	NA	Not Comparable	94.35%
CAP–256	82.89%	80.80%	↔	82.85%
CAP–711	80.30%	81.52%	↔	80.34%
CAP–1219	76.57%	75.98%	↔	76.54%
CDC–BP	59.61%	56.20%	↔	58.74%
CDC–E	40.63%	37.71%	↔	38.35%
CDC–H8 (<8.0%)	38.69%	43.31%	↔	41.99%
CDC–H9 (>9.0%)	54.74%	46.47%	▲	50.24%
CDC–HT	71.53%	82.24%	↑	77.18%
CDC–LC (<100)	29.20%	35.52%	↔	32.77%
CDC–LS	66.42%	75.67%	↑	71.84%
CDC–N	73.24%	84.91%	↑	77.43%
MPM–ACE	79.15%	82.19%	↔	80.77%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	78.81%	83.44%	↔	81.48%

Table B.8—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem Blue Cross Partnership Plan—Fresno County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
231.05	40.31	401.81	69.24

Table B.9—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Anthem Blue Cross Partnership Plan—Kings County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	11.84%	19.82%	↔	16.58%
CAP–1224	95.01%	NA	Not Comparable	95.06%
CAP–256	86.69%	80.00%	↔	86.53%
CAP–711	NA	NA	Not Comparable	NA
CAP–1219	NA	NA	Not Comparable	NA
CDC–BP	59.63%	57.14%	↔	58.44%
CDC–E	41.61%	34.69%	↔	38.31%
CDC–H8 (<8.0%)	37.89%	39.46%	↔	38.64%
CDC–H9 (>9.0%)	55.28%	55.10%	↔	55.19%
CDC–HT	75.78%	74.15%	↔	75.00%
CDC–LC (<100)	26.09%	25.85%	↔	25.97%
CDC–LS	72.67%	73.47%	↔	73.05%
CDC–N	68.94%	78.23%	↔	73.38%
MPM–ACE	84.82%	86.55%	↔	85.71%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	78.13%	90.28%	↔	84.56%

Table B.10—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem Blue Cross Partnership Plan—Kings County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
337.12	61.10	662.36	140.74

Table B.11—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Anthem Blue Cross Partnership Plan—Madera County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	2.50%	17.31%	▼	10.87%
CAP–1224	98.05%	NA	Not Comparable	97.83%
CAP–256	88.48%	90.48%	↔	88.53%
CAP–711	NA	NA	Not Comparable	NA
CAP–1219	NA	NA	Not Comparable	NA
CDC–BP	68.70%	64.29%	↔	66.81%
CDC–E	51.91%	59.18%	↔	55.02%
CDC–H8 (<8.0%)	49.62%	55.10%	↔	51.97%
CDC–H9 (>9.0%)	37.40%	34.69%	↔	36.24%
CDC–HT	79.39%	91.84%	↑	84.72%
CDC–LC (<100)	29.77%	33.67%	↔	31.44%
CDC–LS	70.23%	76.53%	↔	72.93%
CDC–N	74.05%	85.71%	↑	79.04%
MPM–ACE	74.47%	78.72%	↔	76.60%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	65.79%	87.04%	↑	78.26%

Table B.12—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem Blue Cross Partnership Plan—Madera County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
293.16	56.55	542.71	95.08

Table B.13—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Anthem Blue Cross Partnership Plan—Sacramento County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.85%	15.52%	▼	12.63%
CAP–1224	93.23%	88.37%	↔	93.16%
CAP–256	80.26%	77.94%	↔	80.19%
CAP–711	81.02%	83.54%	↔	81.14%
CAP–1219	80.47%	81.66%	↔	80.56%
CDC–BP	55.96%	57.18%	↔	57.04%
CDC–E	29.20%	31.14%	↔	28.16%
CDC–H8 (<8.0%)	37.71%	53.04%	↑	46.12%
CDC–H9 (>9.0%)	53.53%	39.90%	▲	47.09%
CDC–HT	67.40%	81.02%	↑	75.24%
CDC–LC (<100)	22.63%	34.06%	↑	27.18%
CDC–LS	58.15%	71.53%	↑	67.23%
CDC–N	61.07%	80.54%	↑	71.60%
MPM–ACE	60.90%	67.13%	↑	65.15%
MPM–DIG	NA	NA	Not Comparable	86.11%
MPM–DIU	59.22%	70.32%	↑	67.21%

Table B.14—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem Blue Cross Partnership Plan—Sacramento County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
190.39	47.88	331.70	85.17

Table B.15—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Anthem Blue Cross Partnership Plan—San Francisco County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	6.56%	15.35%	↔	14.19%
CAP–1224	96.08%	NA	Not Comparable	96.11%
CAP–256	87.28%	NA	Not Comparable	86.94%
CAP–711	90.74%	94.12%	↔	90.85%
CAP–1219	89.69%	87.78%	↔	89.58%
CDC–BP	60.19%	62.97%	↔	61.80%
CDC–E	39.81%	47.52%	↔	45.26%
CDC–H8 (<8.0%)	48.54%	55.10%	↔	52.55%
CDC–H9 (>9.0%)	37.86%	34.40%	↔	36.01%
CDC–HT	84.47%	87.17%	↔	86.13%
CDC–LC (<100)	31.07%	41.11%	↔	39.17%
CDC–LS	73.79%	76.68%	↔	75.91%
CDC–N	82.52%	86.88%	↔	85.89%
MPM–ACE	77.78%	83.49%	↔	82.57%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	81.13%	82.14%	↔	81.99%

Table B.16—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem Blue Cross Partnership Plan—San Francisco County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
237.72	32.91	349.50	89.99

Table B.17—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Anthem Blue Cross Partnership Plan—San Joaquin County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	8.63%	21.22%	▼	16.00%
CAP–1224	90.82%	NA	Not Comparable	90.61%
CAP–256	78.97%	70.07%	↓	78.63%
CAP–711	78.02%	77.40%	↔	77.99%
CAP–1219	74.75%	74.76%	↔	74.76%
CDC–BP	55.43%	56.36%	↔	54.37%
CDC–E	33.33%	36.36%	↔	32.77%
CDC–H8 (<8.0%)	36.05%	42.42%	↔	40.53%
CDC–H9 (>9.0%)	53.88%	50.30%	↔	50.97%
CDC–HT	72.09%	67.58%	↔	69.42%
CDC–LC (<100)	30.62%	30.61%	↔	28.88%
CDC–LS	68.60%	66.36%	↔	66.26%
CDC–N	69.38%	78.79%	↑	74.76%
MPM–ACE	64.94%	74.91%	↑	71.15%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	66.33%	77.32%	↑	73.63%

Table B.18—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem Blue Cross Partnership Plan—San Joaquin County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
211.40	52.00	335.61	87.32

Table B.19—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Anthem Blue Cross Partnership Plan—Santa Clara County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	12.43%	14.47%	↔	13.74%
CAP–1224	96.07%	NA	Not Comparable	95.81%
CAP–256	87.40%	87.16%	↔	87.39%
CAP–711	88.02%	88.81%	↔	88.05%
CAP–1219	87.64%	87.01%	↔	87.62%
CDC–BP	66.42%	54.26%	↓	58.50%
CDC–E	51.82%	50.61%	↔	49.76%
CDC–H8 (<8.0%)	52.31%	49.39%	↔	53.88%
CDC–H9 (>9.0%)	38.93%	41.36%	↔	39.08%
CDC–HT	83.21%	81.51%	↔	79.85%
CDC–LC (<100)	39.90%	41.61%	↔	35.44%
CDC–LS	79.32%	79.32%	↔	76.94%
CDC–N	79.81%	86.37%	↑	80.10%
MPM–ACE	84.37%	88.02%	↔	86.63%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	85.21%	87.38%	↔	86.61%

Table B.20—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem Blue Cross Partnership Plan—Santa Clara County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
234.32	37.66	364.03	62.01

Table B.21—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Anthem Blue Cross Partnership Plan—Stanislaus County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	8.21%	18.34%	▼	14.07%
CAP–1224	96.14%	NA	Not Comparable	96.18%
CAP–256	86.40%	84.62%	↔	86.34%
CAP–711	87.02%	91.35%	↑	87.24%
CAP–1219	85.38%	85.12%	↔	85.36%
CDC–BP	60.34%	58.15%	↔	57.04%
CDC–E	29.20%	32.36%	↔	33.25%
CDC–H8 (<8.0%)	46.96%	48.18%	↔	47.57%
CDC–H9 (>9.0%)	47.20%	44.04%	↔	43.69%
CDC–HT	74.94%	79.56%	↔	77.18%
CDC–LC (<100)	33.33%	33.09%	↔	31.80%
CDC–LS	70.32%	73.24%	↔	69.42%
CDC–N	70.56%	78.35%	↑	76.94%
MPM–ACE	84.99%	86.26%	↔	85.74%
MPM–DIG	NA	NA	Not Comparable	90.32%
MPM–DIU	85.29%	85.91%	↔	85.70%

Table B.22—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem Blue Cross Partnership Plan—Stanislaus County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
283.46	57.44	553.38	95.33

Table B.23—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Anthem Blue Cross Partnership Plan—Tulare County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.83%	15.70%	▼	11.70%
CAP–1224	92.49%	NA	Not Comparable	92.47%
CAP–256	82.70%	83.87%	↔	82.72%
CAP–711	79.53%	81.43%	↔	79.60%
CAP–1219	82.13%	83.68%	↔	82.20%
CDC–BP	67.88%	63.02%	↔	68.45%
CDC–E	35.52%	36.01%	↔	35.68%
CDC–H8 (<8.0%)	46.47%	46.96%	↔	48.54%
CDC–H9 (>9.0%)	44.28%	42.09%	↔	43.69%
CDC–HT	79.08%	80.78%	↔	78.40%
CDC–LC (<100)	33.33%	35.77%	↔	32.52%
CDC–LS	70.80%	74.70%	↔	69.66%
CDC–N	79.56%	84.18%	↔	81.55%
MPM–ACE	75.69%	82.10%	↑	78.55%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	77.22%	86.27%	↑	81.57%

Table B.24—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Anthem Blue Cross Partnership Plan—Tulare County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
278.32	38.85	494.61	85.58

Table B.25—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
CalOptima—Orange County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	11.35%	18.82%	▼	16.69%
CAP–1224	97.45%	85.60%	↓	97.34%
CAP–256	91.29%	86.36%	↓	91.12%
CAP–711	92.03%	85.40%	↓	91.64%
CAP–1219	90.99%	81.99%	↓	90.41%
CDC–BP	75.12%	70.23%	↔	73.95%
CDC–E	62.09%	70.47%	↑	66.05%
CDC–H8 (<8.0%)	48.60%	65.58%	↑	56.98%
CDC–H9 (>9.0%)	42.33%	29.53%	▲	37.21%
CDC–HT	81.86%	85.58%	↔	82.33%
CDC–LC (<100)	36.28%	46.74%	↑	40.23%
CDC–LS	79.07%	84.42%	↑	80.70%
CDC–N	77.67%	85.81%	↑	83.02%
MPM–ACE	87.58%	91.78%	↑	90.75%
MPM–DIG	91.18%	93.77%	↔	93.54%
MPM–DIU	86.39%	91.88%	↑	90.65%

Table B.26—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
CalOptima—Orange County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
288.81	34.15	559.23	46.80

Table B.27—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population CalViva Health—Fresno County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.69%	12.30%	▼	10.64%
CAP–1224	97.90%	91.46%	↓	97.82%
CAP–256	91.52%	90.62%	↔	91.50%
CAP–711	91.65%	93.76%	↔	91.74%
CAP–1219	90.67%	90.79%	↔	90.68%
CDC–BP	53.16%	49.39%	↔	48.66%
CDC–E	43.20%	50.12%	↑	48.91%
CDC–H8 (<8.0%)	44.17%	45.50%	↔	43.80%
CDC–H9 (>9.0%)	49.76%	42.09%	▲	47.45%
CDC–HT	78.64%	86.62%	↑	82.97%
CDC–LC (<100)	33.98%	38.20%	↔	36.74%
CDC–LS	71.60%	82.00%	↑	76.64%
CDC–N	68.20%	81.27%	↑	75.67%
MPM–ACE	80.26%	83.76%	↑	82.27%
MPM–DIG	NA	89.61%	Not Comparable	86.60%
MPM–DIU	79.47%	85.44%	↑	83.02%

Table B.28—2013 Non-SPD and SPD Rates for Ambulatory Care Measures CalViva Health—Fresno County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
435.84	42.99	551.16	66.02

Table B.29—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population CalViva Health—Kings County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	5.00%	12.69%	↔	10.31%
CAP–1224	96.94%	NA	Not Comparable	96.98%
CAP–256	89.73%	89.47%	↔	89.73%
CAP–711	NA	NA	Not Comparable	NA
CAP–1219	NA	NA	Not Comparable	NA
CDC–BP	48.28%	49.53%	↔	50.36%
CDC–E	41.87%	41.59%	↔	42.82%
CDC–H8 (<8.0%)	32.02%	37.85%	↔	41.85%
CDC–H9 (>9.0%)	40.89%	34.11%	↔	50.85%
CDC–HT	55.17%	49.07%	↔	80.54%
CDC–LC (<100)	16.75%	28.50%	↑	27.98%
CDC–LS	53.69%	49.07%	↔	74.94%
CDC–N	72.41%	82.24%	↑	78.35%
MPM–ACE	74.65%	85.71%	↑	80.23%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	71.18%	86.11%	↑	78.03%

Table B.30—2013 Non-SPD and SPD Rates for Ambulatory Care Measures CalViva Health—Kings County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
419.16	53.80	737.46	115.90

Table B.31—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
CalViva Health—Madera County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.41%	14.04%	↔	10.81%
CAP–1224	98.67%	NA	Not Comparable	98.53%
CAP–256	91.77%	90.79%	↔	91.75%
CAP–711	NA	NA	Not Comparable	NA
CAP–1219	NA	NA	Not Comparable	NA
CDC–BP	62.78%	51.85%	↓	59.37%
CDC–E	50.81%	59.26%	↔	55.72%
CDC–H8 (<8.0%)	44.98%	48.61%	↔	46.47%
CDC–H9 (>9.0%)	44.01%	43.98%	↔	43.31%
CDC–HT	82.52%	89.35%	↑	85.89%
CDC–LC (<100)	33.66%	32.87%	↔	33.09%
CDC–LS	69.26%	74.54%	↔	70.32%
CDC–N	77.35%	84.26%	↔	81.27%
MPM–ACE	76.08%	87.11%	↑	80.80%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	75.86%	88.55%	↑	81.88%

Table B.32—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
CalViva Health—Madera County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
425.90	48.98	648.89	72.47

Table B.33—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Care1st Partner Plan—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	8.65%	17.35%	▼	15.64%
CAP–1224	93.78%	NA	Not Comparable	93.54%
CAP–256	83.10%	70.83%	↓	82.76%
CAP–711	82.68%	82.50%	↔	82.67%
CAP–1219	81.22%	78.13%	↔	81.15%
CDC–BP	63.36%	57.00%	↔	58.39%
CDC–E	40.46%	38.40%	↔	40.39%
CDC–H8 (<8.0%)	38.17%	45.20%	↔	51.82%
CDC–H9 (>9.0%)	52.67%	48.00%	↔	42.09%
CDC–HT	83.21%	82.80%	↔	84.91%
CDC–LC (<100)	35.11%	38.60%	↔	37.23%
CDC–LS	74.81%	79.40%	↔	78.59%
CDC–N	80.92%	88.40%	↑	85.40%
MPM–ACE	84.85%	81.13%	↔	81.79%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	75.23%	81.24%	↔	80.19%

Table B.34—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Care1st Partner Plan—San Diego County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
249.97	43.32	415.00	73.34

Table B.35—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
CenCal Health—San Luis Obispo County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	6.70%	16.54%	▼	13.49%
CAP–1224	95.37%	NA	Not Comparable	95.31%
CAP–256	86.59%	73.87%	↓	86.21%
CAP–711	87.92%	83.22%	↔	87.64%
CAP–1219	87.58%	76.61%	↓	86.69%
CDC–BP	70.23%	72.67%	↔	70.56%
CDC–E	47.91%	57.27%	↑	58.39%
CDC–H8 (<8.0%)	47.44%	60.47%	↑	61.31%
CDC–H9 (>9.0%)	48.37%	34.01%	▲	31.14%
CDC–HT	75.81%	83.14%	↑	82.00%
CDC–LC (<100)	32.56%	45.35%	↑	42.58%
CDC–LS	73.95%	81.69%	↑	79.56%
CDC–N	72.09%	88.08%	↑	82.73%
MPM–ACE	74.84%	83.88%	↑	81.02%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	78.57%	86.25%	↔	84.20%

Table B.36—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
CenCal Health—San Luis Obispo County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
303.89	57.42	599.51	100.09

Table B.37—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
CenCal Health—Santa Barbara County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	5.54%	13.88%	▼	11.13%
CAP–1224	97.87%	NA	Not Comparable	97.84%
CAP–256	91.26%	86.40%	↓	91.16%
CAP–711	91.01%	87.97%	↔	90.88%
CAP–1219	89.25%	89.83%	↔	89.29%
CDC–BP	71.78%	68.61%	↔	74.21%
CDC–E	64.96%	68.37%	↔	70.56%
CDC–H8 (<8.0%)	56.45%	61.07%	↔	59.61%
CDC–H9 (>9.0%)	38.69%	31.39%	▲	33.58%
CDC–HT	81.51%	84.91%	↔	83.94%
CDC–LC (<100)	36.25%	42.09%	↔	38.93%
CDC–LS	76.16%	81.27%	↔	80.54%
CDC–N	80.54%	85.89%	↑	82.48%
MPM–ACE	80.90%	86.86%	↑	84.72%
MPM–DIG	NA	87.10%	Not Comparable	86.11%
MPM–DIU	78.97%	88.10%	↑	85.46%

Table B.38—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
CenCal Health—Santa Barbara County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
308.44	46.35	566.20	101.65

Table B.39—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Central California Alliance for Health—Merced County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.86%	14.40%	▼	12.73%
CAP–1224	97.51%	90.32%	↓	97.42%
CAP–256	90.37%	91.17%	↔	90.39%
CAP–711	89.76%	90.89%	↔	89.82%
CAP–1219	90.30%	88.74%	↔	90.19%
CDC–BP	69.34%	61.80%	↓	64.96%
CDC–E	49.88%	53.28%	↔	54.74%
CDC–H8 (<8.0%)	45.26%	48.66%	↔	46.72%
CDC–H9 (>9.0%)	45.50%	43.80%	↔	45.99%
CDC–HT	84.18%	84.67%	↔	84.91%
CDC–LC (<100)	33.58%	33.33%	↔	33.09%
CDC–LS	81.75%	79.32%	↔	80.54%
CDC–N	82.00%	86.13%	↔	84.91%
MPM–ACE	86.26%	87.83%	↔	87.14%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	84.96%	88.28%	↔	86.97%

Table B.40—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Central California Alliance for Health—Merced County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
299.06	51.12	536.12	75.54

Table B.41—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Central California Alliance for Health—Monterey/Santa Cruz Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.78%	14.47%	▼	12.06%
CAP–1224	98.50%	96.67%	↔	98.49%
CAP–256	91.26%	92.76%	↔	91.29%
CAP–711	90.86%	91.46%	↔	90.89%
CAP–1219	91.17%	88.47%	↓	91.00%
CDC–BP	76.16%	65.21%	↓	71.05%
CDC–E	61.56%	63.99%	↔	63.02%
CDC–H8 (<8.0%)	48.42%	51.58%	↔	51.09%
CDC–H9 (>9.0%)	39.90%	36.98%	↔	36.98%
CDC–HT	85.64%	86.37%	↔	87.35%
CDC–LC (<100)	38.20%	40.88%	↔	39.66%
CDC–LS	79.81%	76.16%	↔	78.83%
CDC–N	76.16%	81.02%	↔	79.32%
MPM–ACE	80.15%	89.32%	↑	85.86%
MPM–DIG	NA	89.13%	Not Comparable	89.47%
MPM–DIU	78.84%	88.86%	↑	85.58%

Table B.42—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Central California Alliance for Health—Monterey/Santa Cruz Counties

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
293.93	49.10	543.55	79.25

**Table B.43—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Community Health Group Partnership Plan—San Diego County**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	10.79%	17.03%	▼	14.37%
CAP–1224	97.34%	NA	Not Comparable	97.32%
CAP–256	89.87%	88.46%	↔	89.85%
CAP–711	89.76%	94.09%	↑	89.90%
CAP–1219	88.70%	87.12%	↔	88.64%
CDC–BP	65.69%	62.53%	↔	64.72%
CDC–E	53.77%	60.58%	↑	55.47%
CDC–H8 (<8.0%)	56.69%	58.88%	↔	56.45%
CDC–H9 (>9.0%)	34.55%	30.66%	↔	34.31%
CDC–HT	86.86%	90.27%	↔	90.02%
CDC–LC (<100)	38.69%	46.47%	↑	39.66%
CDC–LS	82.24%	86.62%	↔	83.70%
CDC–N	80.05%	88.08%	↑	83.21%
MPM–ACE	84.91%	85.05%	↔	84.99%
MPM–DIG	NA	90.24%	Not Comparable	91.23%
MPM–DIU	84.06%	85.76%	↔	85.04%

**Table B.44—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Community Health Group Partnership Plan—San Diego County**

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
287.97	34.30	495.48	62.49

Table B.45—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Contra Costa Health Plan—Contra Costa County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	12.72%	19.48%	▼	16.99%
CAP–1224	86.81%	NA	Not Comparable	86.74%
CAP–256	76.24%	74.13%	↔	76.18%
CAP–711	77.74%	82.34%	↑	77.96%
CAP–1219	74.46%	79.63%	↑	74.86%
CDC–BP	59.85%	56.20%	↔	59.37%
CDC–E	49.88%	54.50%	↔	51.09%
CDC–H8 (<8.0%)	40.88%	55.96%	↑	49.88%
CDC–H9 (>9.0%)	51.34%	33.82%	▲	40.39%
CDC–HT	81.27%	88.56%	↑	85.40%
CDC–LC (<100)	33.58%	43.55%	↑	41.61%
CDC–LS	76.16%	84.43%	↑	82.00%
CDC–N	75.91%	86.13%	↑	82.00%
MPM–ACE	78.37%	85.68%	↑	83.77%
MPM–DIG	NA	86.54%	Not Comparable	85.71%
MPM–DIU	77.84%	85.83%	↑	83.68%

Table B.46—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Contra Costa Health Plan—Contra Costa County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
199.28	55.98	299.06	83.56

Table B.47—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Gold Coast Health Plan—Ventura County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	11.32%	23.16%	▼	19.17%
CAP–1224	82.60%	75.00%	↔	82.51%
CAP–256	63.12%	61.92%	↔	63.09%
CAP–711	NA	NA	Not Comparable	NA
CAP–1219	NA	NA	Not Comparable	NA
CDC–BP	65.69%	57.66%	↓	62.29%
CDC–E	44.04%	44.53%	↔	42.58%
CDC–H8 (<8.0%)	37.71%	35.04%	↔	37.96%
CDC–H9 (>9.0%)	54.99%	58.64%	↔	56.20%
CDC–HT	82.73%	85.16%	↔	81.75%
CDC–LC (<100)	33.82%	36.25%	↔	33.58%
CDC–LS	77.37%	79.08%	↔	78.83%
CDC–N	80.78%	86.13%	↑	79.81%
MPM–ACE	84.26%	88.46%	↑	86.73%
MPM–DIG	NA	88.37%	Not Comparable	88.46%
MPM–DIU	85.15%	86.97%	↔	86.28%

Table B.48—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Gold Coast Health Plan—Ventura County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
294.22	46.49	493.66	70.16

Table B.49—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Net Community Solutions, Inc.—Kern County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.36%	11.72%	▼	10.40%
CAP–1224	89.99%	NA	Not Comparable	89.78%
CAP–256	70.52%	68.83%	↔	70.48%
CAP–711	68.00%	72.27%	↔	68.16%
CAP–1219	76.72%	73.89%	↔	76.57%
CDC–BP	49.14%	48.66%	↔	50.12%
CDC–E	49.88%	43.55%	↔	44.28%
CDC–H8 (<8.0%)	32.84%	40.15%	↑	38.20%
CDC–H9 (>9.0%)	59.01%	49.15%	▲	52.80%
CDC–HT	68.64%	73.24%	↔	73.24%
CDC–LC (<100)	28.89%	40.88%	↑	38.93%
CDC–LS	64.20%	75.91%	↑	72.75%
CDC–N	75.56%	83.21%	↑	80.78%
MPM–ACE	70.82%	78.34%	↑	75.85%
MPM–DIG	NA	NA	Not Comparable	83.33%
MPM–DIU	70.73%	78.90%	↑	76.59%

Table B.50—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net Community Solutions, Inc.—Kern County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
196.35	47.99	219.48	80.74

Table B.51—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Net Community Solutions, Inc.—Los Angeles County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.58%	14.16%	▼	11.93%
CAP–1224	94.35%	86.07%	↓	94.29%
CAP–256	81.21%	76.93%	↓	81.11%
CAP–711	83.10%	83.57%	↔	83.12%
CAP–1219	83.01%	78.40%	↓	82.82%
CDC–BP	53.04%	50.36%	↔	50.12%
CDC–E	51.09%	43.55%	↓	47.69%
CDC–H8 (<8.0%)	35.04%	45.50%	↑	39.90%
CDC–H9 (>9.0%)	51.34%	44.28%	▲	48.42%
CDC–HT	78.83%	78.83%	↔	78.10%
CDC–LC (<100)	31.63%	38.20%	↑	35.52%
CDC–LS	75.91%	78.10%	↔	75.43%
CDC–N	81.27%	84.43%	↔	82.97%
MPM–ACE	74.64%	77.01%	↑	76.09%
MPM–DIG	83.33%	86.48%	↔	85.92%
MPM–DIU	72.64%	78.39%	↑	76.27%

Table B.52—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net Community Solutions, Inc.—Los Angeles County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
248.68	33.35	267.73	55.77

Table B.53—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Net Community Solutions, Inc.—Sacramento County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	6.02%	14.03%	▼	12.15%
CAP–1224	92.71%	NA	Not Comparable	92.53%
CAP–256	80.23%	78.66%	↔	80.19%
CAP–711	80.41%	86.48%	↑	80.69%
CAP–1219	81.67%	81.16%	↔	81.64%
CDC–BP	50.12%	48.91%	↔	48.91%
CDC–E	36.98%	37.71%	↔	40.63%
CDC–H8 (<8.0%)	39.66%	49.64%	↑	43.55%
CDC–H9 (>9.0%)	51.34%	39.42%	▲	45.26%
CDC–HT	72.51%	80.78%	↑	77.86%
CDC–LC (<100)	23.60%	37.96%	↑	35.77%
CDC–LS	59.61%	71.78%	↑	67.40%
CDC–N	72.51%	85.64%	↑	83.45%
MPM–ACE	61.52%	69.20%	↑	67.16%
MPM–DIG	NA	83.93%	Not Comparable	82.46%
MPM–DIU	56.74%	71.03%	↑	67.40%

Table B.54—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net Community Solutions, Inc.—Sacramento County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
274.99	39.84	399.51	65.06

**Table B.55—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Net Community Solutions, Inc.—San Diego County**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.38%	17.88%	▼	15.96%
CAP–1224	94.45%	NA	Not Comparable	93.98%
CAP–256	85.41%	81.31%	↔	85.27%
CAP–711	84.87%	85.96%	↔	84.91%
CAP–1219	82.60%	80.42%	↔	82.51%
CDC–BP	50.18%	53.28%	↔	52.07%
CDC–E	47.67%	43.31%	↔	45.99%
CDC–H8 (<8.0%)	43.01%	51.82%	↑	50.85%
CDC–H9 (>9.0%)	48.75%	37.71%	▲	41.61%
CDC–HT	78.49%	86.37%	↑	85.40%
CDC–LC (<100)	28.32%	43.80%	↑	41.12%
CDC–LS	68.82%	81.75%	↑	79.08%
CDC–N	70.97%	87.59%	↑	82.24%
MPM–ACE	76.98%	86.17%	↑	83.68%
MPM–DIG	NA	NA	Not Comparable	100.00%
MPM–DIU	75.42%	86.79%	↑	83.82%

**Table B.56—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net Community Solutions, Inc.—San Diego County**

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
296.72	46.14	406.58	71.22

Table B.57—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Net Community Solutions, Inc.—Stanislaus County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	5.66%	10.12%	↔	8.71%
CAP–1224	97.12%	NA	Not Comparable	97.04%
CAP–256	87.18%	86.27%	↔	87.15%
CAP–711	84.96%	90.98%	↔	85.24%
CAP–1219	85.74%	94.25%	↑	86.00%
CDC–BP	58.30%	60.58%	↔	58.39%
CDC–E	45.56%	41.12%	↔	41.61%
CDC–H8 (<8.0%)	50.19%	60.10%	↑	56.93%
CDC–H9 (>9.0%)	36.29%	30.17%	↔	31.87%
CDC–HT	85.33%	89.78%	↔	88.32%
CDC–LC (<100)	29.34%	42.82%	↑	34.55%
CDC–LS	76.83%	81.27%	↔	78.59%
CDC–N	74.13%	82.97%	↑	78.59%
MPM–ACE	84.65%	83.26%	↔	83.73%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	80.25%	86.47%	↔	84.46%

Table B.58—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net Community Solutions, Inc.—Stanislaus County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
350.80	50.77	491.16	82.73

Table B.59—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Net Community Solutions, Inc.—Tulare County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	5.79%	15.86%	▼	11.86%
CAP–1224	97.78%	NA	Not Comparable	97.76%
CAP–256	92.30%	94.74%	↔	92.37%
CAP–711	91.58%	94.50%	↔	91.72%
CAP–1219	93.09%	92.00%	↔	93.05%
CDC–BP	58.64%	49.39%	↓	54.26%
CDC–E	43.55%	45.01%	↔	41.85%
CDC–H8 (<8.0%)	44.53%	53.77%	↑	49.64%
CDC–H9 (>9.0%)	45.50%	38.93%	↔	43.55%
CDC–HT	84.43%	87.59%	↔	86.62%
CDC–LC (<100)	30.90%	38.20%	↑	36.50%
CDC–LS	73.97%	76.64%	↔	77.86%
CDC–N	79.81%	82.73%	↔	82.00%
MPM–ACE	83.16%	83.74%	↔	83.50%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	79.55%	87.50%	↑	84.60%

Table B.60—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net Community Solutions, Inc.—Tulare County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
449.45	37.86	602.84	71.55

Table B.61—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Plan of San Joaquin—San Joaquin County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	6.27%	13.75%	▼	7.07%
CAP–1224	97.51%	96.30%	↔	97.49%
CAP–256	87.52%	89.90%	↔	87.59%
CAP–711	85.55%	88.53%	↔	85.71%
CAP–1219	84.77%	87.69%	↑	84.94%
CDC–BP	60.34%	63.26%	↔	78.28%
CDC–E	42.58%	45.01%	↔	45.62%
CDC–H8 (<8.0%)	45.99%	51.09%	↔	52.37%
CDC–H9 (>9.0%)	47.20%	43.55%	↔	39.60%
CDC–HT	77.62%	82.00%	↔	80.66%
CDC–LC (<100)	27.74%	34.79%	↑	35.22%
CDC–LS	71.29%	77.86%	↑	75.55%
CDC–N	76.40%	82.24%	↑	82.12%
MPM–ACE	80.70%	85.44%	↑	83.69%
MPM–DIG	NA	90.91%	Not Comparable	92.11%
MPM–DIU	81.44%	86.39%	↑	84.58%

Table B.62—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Plan of San Joaquin—San Joaquin County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
246.24	43.01	474.21	72.22

Table B.63—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Plan of San Mateo—San Mateo County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	19.24%	13.28%	▲	14.52%
CAP–1224	96.98%	79.41%	↓	96.70%
CAP–256	88.77%	74.72%	↓	88.32%
CAP–711	90.72%	72.19%	↓	89.36%
CAP–1219	87.60%	65.03%	↓	85.61%
CDC–BP	13.38%	48.18%	↑	56.93%
CDC–E	32.36%	57.42%	↑	57.42%
CDC–H8 (<8.0%)	46.47%	55.72%	↑	56.45%
CDC–H9 (>9.0%)	35.52%	46.72%	▼	35.28%
CDC–HT	78.35%	83.94%	↑	83.70%
CDC–LC (<100)	30.90%	48.18%	↑	46.96%
CDC–LS	69.34%	83.21%	↑	80.78%
CDC–N	73.97%	85.16%	↑	82.97%
MPM–ACE	85.52%	89.95%	↑	89.51%
MPM–DIG	NA	94.79%	Not Comparable	94.95%
MPM–DIU	84.70%	91.23%	↑	90.57%

Table B.64—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Plan of San Mateo—San Mateo County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
405.92	49.86	924.90	58.21

Table B.65—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Inland Empire Health Plan—San Bernardino/Riverside County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.82%	16.95%	▼	14.24%
CAP–1224	96.76%	96.12%	↔	96.75%
CAP–256	86.92%	86.54%	↔	86.91%
CAP–711	82.97%	87.66%	↑	83.18%
CAP–1219	86.73%	86.60%	↔	86.72%
CDC–BP	68.19%	67.12%	↔	71.00%
CDC–E	52.94%	60.59%	↑	59.40%
CDC–H8 (<8.0%)	42.70%	57.43%	↑	50.81%
CDC–H9 (>9.0%)	46.19%	31.31%	▲	36.19%
CDC–HT	79.74%	86.49%	↑	85.61%
CDC–LC (<100)	34.64%	48.65%	↑	42.00%
CDC–LS	76.03%	86.49%	↑	83.53%
CDC–N	75.60%	86.71%	↑	84.45%
MPM–ACE	83.14%	89.22%	↑	86.98%
MPM–DIG	96.23%	91.32%	↔	91.99%
MPM–DIU	81.24%	88.78%	↑	86.07%

Table B.66—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Inland Empire Health Plan—San Bernardino/Riverside County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
308.23	48.29	630.72	75.75

**Table B.67—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Kaiser–Sacramento County**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	11.63%	17.05%	↔	15.71%
CAP–1224	98.34%	NA	Not Comparable	98.38%
CAP–256	90.10%	95.58%	↑	90.32%
CAP–711	91.52%	95.56%	↑	91.82%
CAP–1219	92.23%	94.80%	↑	92.53%
CDC–BP	82.01%	80.69%	↔	79.87%
CDC–E	65.24%	70.60%	↔	66.16%
CDC–H8 (<8.0%)	50.61%	66.30%	↑	59.37%
CDC–H9 (>9.0%)	34.45%	20.05%	▲	27.30%
CDC–HT	91.46%	96.19%	↑	94.09%
CDC–LC (<100)	57.62%	73.68%	↑	66.79%
CDC–LS	89.94%	95.20%	↑	92.70%
CDC–N	85.67%	92.87%	↑	89.18%
MPM–ACE	89.80%	96.27%	↑	94.54%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	90.72%	95.25%	↑	93.99%

**Table B.68—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Kaiser–Sacramento County**

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
347.03	49.88	671.49	86.57

Table B.69—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Kaiser–San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	6.67%	20.74%	▼	17.51%
CAP–1224	99.51%	NA	Not Comparable	99.52%
CAP–256	94.23%	98.70%	↔	94.40%
CAP–711	95.14%	97.80%	↔	95.31%
CAP–1219	97.23%	93.57%	↓	96.97%
CDC–BP	87.01%	84.15%	↔	85.10%
CDC–E	71.43%	78.37%	↑	76.07%
CDC–H8 (<8.0%)	63.64%	73.02%	↑	69.91%
CDC–H9 (>9.0%)	23.38%	15.85%	▲	18.34%
CDC–HT	94.81%	94.86%	↔	94.84%
CDC–LC (<100)	60.61%	74.52%	↑	69.91%
CDC–LS	90.91%	93.79%	↔	92.84%
CDC–N	90.91%	94.65%	↔	93.41%
MPM–ACE	91.74%	94.76%	↔	93.22%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	91.46%	94.24%	↔	92.74%

Table B.70—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Kaiser–San Diego County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
415.75	35.60	737.64	52.40

Table B.71—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population Kern Family Health Care—Kern County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	6.27%	17.07%	▼	8.77%
CAP–1224	92.43%	87.76%	↔	92.37%
CAP–256	82.13%	86.32%	↔	82.18%
CAP–711	79.38%	85.00%	↔	79.43%
CAP–1219	82.19%	85.37%	↔	82.20%
CDC–BP	75.73%	73.72%	↔	75.36%
CDC–E	43.98%	48.18%	↔	45.80%
CDC–H8 (<8.0%)	46.53%	56.57%	↑	47.45%
CDC–H9 (>9.0%)	46.35%	36.31%	▲	44.53%
CDC–HT	77.37%	83.21%	↑	80.29%
CDC–LC (<100)	31.39%	40.69%	↑	33.58%
CDC–LS	72.99%	83.76%	↑	76.28%
CDC–N	76.09%	84.85%	↑	77.55%
MPM–ACE	85.38%	92.05%	↑	87.71%
MPM–DIG	NA	NA	Not Comparable	90.74%
MPM–DIU	85.34%	91.17%	↑	87.62%

Table B.72—2013 Non-SPD and SPD Rates for Ambulatory Care Measures Kern Family Health Care—Kern County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
240.89	48.21	487.16	95.53

Table B.73—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
L.A. Care Health Plan—Los Angeles County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	10.99%	19.69%	▼	17.05%
CAP–1224	91.20%	77.40%	↓	91.06%
CAP–256	82.97%	81.54%	↓	82.93%
CAP–711	87.12%	87.85%	↔	87.15%
CAP–1219	85.96%	84.37%	↓	85.89%
CDC–BP	57.66%	54.01%	↔	65.94%
CDC–E	43.55%	47.69%	↔	49.76%
CDC–H8 (<8.0%)	41.61%	43.80%	↔	48.07%
CDC–H9 (>9.0%)	48.42%	45.26%	↔	39.37%
CDC–HT	79.56%	81.51%	↔	84.30%
CDC–LC (<100)	29.68%	36.98%	↑	37.68%
CDC–LS	75.67%	78.83%	↔	79.95%
CDC–N	76.64%	82.97%	↑	81.64%
MPM–ACE	72.80%	73.17%	↔	73.03%
MPM–DIG	75.57%	78.75%	↔	78.09%
MPM–DIU	71.64%	73.59%	↑	72.87%

Table B.74—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
L.A. Care Health Plan—Los Angeles County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
169.83	27.42	284.56	61.70

Table B.75—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Molina Healthcare of California Partner Plan, Inc.—Sacramento County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.02%	14.68%	▼	13.20%
CAP–1224	94.90%	NA	Not Comparable	94.81%
CAP–256	84.18%	79.27%	↔	84.09%
CAP–711	83.64%	87.88%	↔	83.80%
CAP–1219	84.55%	79.40%	↓	84.20%
CDC–BP	57.40%	55.80%	↔	54.65%
CDC–E	44.84%	47.83%	↔	47.91%
CDC–H8 (<8.0%)	38.12%	52.17%	↑	46.05%
CDC–H9 (>9.0%)	50.22%	44.20%	↔	43.26%
CDC–HT	74.44%	73.91%	↔	78.60%
CDC–LC (<100)	27.35%	34.06%	↔	31.63%
CDC–LS	64.13%	63.77%	↔	70.00%
CDC–N	71.30%	81.88%	↑	80.47%
MPM–ACE	71.60%	74.59%	↔	73.99%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	70.51%	74.40%	↔	73.63%

Table B.76—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Molina Healthcare of California Partner Plan, Inc.—Sacramento County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
218.18	42.97	415.90	65.28

**Table B.77—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Molina Healthcare of California Partner Plan, Inc.—San Bernardino/Riverside Counties**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.17%	18.15%	▼	14.65%
CAP–1224	93.77%	NA	Not Comparable	93.65%
CAP–256	83.13%	79.18%	↔	83.03%
CAP–711	81.88%	84.52%	↔	81.96%
CAP–1219	84.55%	83.44%	↔	84.51%
CDC–BP	67.63%	56.25%	↓	56.52%
CDC–E	46.89%	46.88%	↔	46.68%
CDC–H8 (<8.0%)	42.32%	47.40%	↔	43.48%
CDC–H9 (>9.0%)	46.06%	44.79%	↔	43.71%
CDC–HT	84.23%	80.21%	↔	81.92%
CDC–LC (<100)	37.76%	42.19%	↔	35.93%
CDC–LS	84.65%	76.56%	↓	82.61%
CDC–N	83.40%	88.02%	↔	83.30%
MPM–ACE	83.14%	87.80%	↑	86.05%
MPM–DIG	NA	90.63%	Not Comparable	92.11%
MPM–DIU	80.14%	87.06%	↑	84.41%

**Table B.78—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Molina Healthcare of California Partner Plan, Inc.—San Bernardino/Riverside Counties**

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
247.94	40.14	346.49	67.24

Table B.79—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Molina Healthcare of California Partner Plan, Inc.—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.37%	17.65%	▼	14.45%
CAP–1224	96.16%	80.65%	↓	95.93%
CAP–256	88.11%	84.13%	↔	88.02%
CAP–711	88.25%	89.63%	↔	88.31%
CAP–1219	85.32%	84.01%	↔	85.26%
CDC–BP	60.21%	58.45%	↔	62.30%
CDC–E	45.42%	52.11%	↔	58.55%
CDC–H8 (<8.0%)	46.83%	57.75%	↑	57.85%
CDC–H9 (>9.0%)	42.25%	37.32%	↔	32.55%
CDC–HT	81.69%	85.21%	↔	88.76%
CDC–LC (<100)	33.80%	51.41%	↑	47.54%
CDC–LS	72.18%	83.80%	↑	86.42%
CDC–N	71.13%	90.14%	↑	84.31%
MPM–ACE	83.63%	85.79%	↔	85.15%
MPM–DIG	NA	94.12%	Not Comparable	94.74%
MPM–DIU	81.40%	88.10%	↑	86.01%

Table B.80—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Molina Healthcare of California Partner Plan, Inc.—San Diego County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
273.91	43.19	512.86	61.02

Table B.81—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Partnership HealthPlan of California—Marin County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	3.70%	18.83%	▼	16.04%
CAP–1224	98.75%	NA	Not Comparable	98.76%
CAP–256	87.92%	77.97%	↓	87.69%
CAP–711	NA	NA	Not Comparable	NA
CAP–1219	NA	NA	Not Comparable	NA
CDC–BP	62.82%	59.77%	↔	60.71%
CDC–E	41.03%	43.10%	↔	42.46%
CDC–H8 (<8.0%)	39.74%	55.17%	↑	50.40%
CDC–H9 (>9.0%)	50.00%	35.63%	▲	40.08%
CDC–HT	84.62%	89.08%	↔	87.70%
CDC–LC (<100)	30.77%	35.63%	↔	34.13%
CDC–LS	65.38%	73.56%	↔	71.03%
CDC–N	70.51%	83.33%	↑	79.37%
MPM–ACE	67.24%	79.13%	↔	76.74%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	65.91%	79.43%	↔	76.71%

Table B.82—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Partnership HealthPlan of California—Marin County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
275.93	45.40	441.02	62.43

Table B.83—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Partnership HealthPlan of California—Mendocino County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	8.03%	10.68%	↔	9.81%
CAP–1224	95.44%	NA	Not Comparable	95.45%
CAP–256	89.08%	NA	Not Comparable	89.15%
CAP–711	NA	NA	Not Comparable	NA
CAP–1219	NA	NA	Not Comparable	NA
CDC–BP	61.25%	54.51%	↔	57.18%
CDC–E	31.88%	43.44%	↑	38.86%
CDC–H8 (<8.0%)	45.00%	52.87%	↔	49.75%
CDC–H9 (>9.0%)	40.00%	35.66%	↔	37.38%
CDC–HT	95.63%	90.98%	↔	92.82%
CDC–LC (<100)	32.50%	40.57%	↔	37.38%
CDC–LS	75.00%	77.87%	↔	76.73%
CDC–N	71.25%	83.61%	↑	78.71%
MPM–ACE	79.55%	86.52%	↔	84.48%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	78.57%	88.14%	↔	85.61%

Table B.84—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Partnership HealthPlan of California—Mendocino County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
289.83	51.97	589.67	94.82

Table B.85—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Partnership HealthPlan of California—Napa/Solano/Yolo Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	6.84%	15.67%	▼	13.25%
CAP–1224	96.69%	86.79%	↓	96.49%
CAP–256	86.57%	82.56%	↓	86.42%
CAP–711	83.59%	84.64%	↔	83.67%
CAP–1219	85.36%	81.91%	↓	84.94%
CDC–BP	69.54%	61.95%	↓	66.67%
CDC–E	52.54%	53.54%	↔	53.42%
CDC–H8 (<8.0%)	49.67%	54.65%	↔	53.64%
CDC–H9 (>9.0%)	37.75%	33.19%	↔	35.76%
CDC–HT	87.64%	85.62%	↔	85.65%
CDC–LC (<100)	37.75%	43.81%	↔	42.16%
CDC–LS	78.15%	77.88%	↔	77.70%
CDC–N	82.12%	88.72%	↑	84.33%
MPM–ACE	78.93%	86.70%	↑	84.46%
MPM–DIG	NA	91.07%	Not Comparable	90.48%
MPM–DIU	74.90%	85.26%	↑	82.35%

Table B.86—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Partnership HealthPlan of California—Napa/Solano/Yolo Counties

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
274.50	47.01	503.87	79.44

**Table B.87—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Partnership HealthPlan of California—Sonoma County**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.01%	15.38%	▼	13.05%
CAP–1224	96.29%	NA	Not Comparable	96.25%
CAP–256	88.48%	94.74%	↑	88.58%
CAP–711	85.78%	84.06%	↔	85.70%
CAP–1219	88.24%	88.04%	↔	88.23%
CDC–BP	73.95%	67.77%	↔	69.98%
CDC–E	52.99%	59.60%	↔	57.62%
CDC–H8 (<8.0%)	48.50%	56.07%	↑	51.66%
CDC–H9 (>9.0%)	37.72%	30.91%	▲	34.88%
CDC–HT	90.12%	93.38%	↔	92.27%
CDC–LC (<100)	37.43%	46.58%	↑	39.74%
CDC–LS	78.14%	77.04%	↔	76.60%
CDC–N	79.04%	84.33%	↔	80.13%
MPM–ACE	68.61%	69.54%	↔	69.27%
MPM–DIG	NA	84.38%	Not Comparable	85.29%
MPM–DIU	62.90%	75.51%	↑	72.08%

**Table B.88—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Partnership HealthPlan of California—Sonoma County**

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
306.38	38.92	577.11	74.66

Table B.89—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
San Francisco Health Plan—San Francisco County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	7.59%	18.08%	▼	15.81%
CAP–1224	95.91%	NA	Not Comparable	95.95%
CAP–256	89.65%	83.67%	↔	89.57%
CAP–711	93.25%	90.85%	↔	93.16%
CAP–1219	91.27%	87.06%	↔	91.13%
CDC–BP	76.39%	73.38%	↔	74.77%
CDC–E	69.68%	63.43%	↔	67.59%
CDC–H8 (<8.0%)	61.11%	65.97%	↔	62.27%
CDC–H9 (>9.0%)	27.78%	24.54%	↔	26.39%
CDC–HT	90.97%	90.51%	↔	90.97%
CDC–LC (<100)	48.61%	50.69%	↔	47.69%
CDC–LS	81.25%	81.48%	↔	80.56%
CDC–N	85.88%	87.27%	↔	87.73%
MPM–ACE	73.62%	77.85%	↑	76.81%
MPM–DIG	NA	80.56%	Not Comparable	81.82%
MPM–DIU	74.36%	79.97%	↑	78.74%

Table B.90—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
San Francisco Health Plan—San Francisco County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
300.16	24.57	527.95	74.89

Table B.91—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Santa Clara Family Health Plan—Santa Clara County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	8.26%	16.54%	▼	13.77%
CAP–1224	96.87%	96.30%	↔	96.87%
CAP–256	88.91%	88.74%	↔	88.90%
CAP–711	88.91%	89.16%	↔	88.92%
CAP–1219	87.74%	89.55%	↔	87.81%
CDC–BP	55.72%	53.53%	↔	53.53%
CDC–E	38.20%	40.15%	↔	41.85%
CDC–H8 (<8.0%)	48.18%	61.07%	↑	55.47%
CDC–H9 (>9.0%)	41.61%	29.20%	▲	34.79%
CDC–HT	82.73%	89.05%	↑	86.62%
CDC–LC (<100)	35.77%	47.93%	↑	42.82%
CDC–LS	73.72%	84.67%	↑	79.08%
CDC–N	74.94%	87.83%	↑	79.81%
MPM–ACE	84.67%	88.79%	↑	87.60%
MPM–DIG	NA	89.33%	Not Comparable	88.10%
MPM–DIU	83.20%	90.07%	↑	88.08%

Table B.92—2013 Non-SPD and SPD Rates for Ambulatory Care Measures
Santa Clara Family Health Plan—Santa Clara County

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
244.89	33.44	403.89	42.92

Appendix C. Individual Managed Care Plan Quality Improvement Project Information

The following key applies to the quality improvement project domain(s) of care and interventions tables only. All other quality improvement project tables have separate keys.

Symbol	Definition
Q	Quality Domain of Care: The degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.
A	Access Domain of Care: An MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries.
T	Timeliness Domain of Care: An MCP's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

NOTE: No outcomes table is included for the following MCPs because their QIPs did not progress to the Outcomes stage:

- Alameda Alliance for Health
- CalViva Health
- Central California Alliance for Health
- Gold Coast Health Plan
- Kaiser–San Diego County
- Kern Family Health Care
- San Francisco Health Plan
- Santa Clara Family Health Plan

Table C.1—Quality Improvement Project Domain(s) of Care and Interventions
AIDS Healthcare Foundation—Los Angeles County
July 1, 2012, through June 30, 2013

QIP #1—Advance Care Directives		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Nonclinical	Q	◆ Provider newsletter ◆ Provider education ◆ In-depth provider training ◆ Member education
QIP #2—CD4 and Viral Load Testing		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Provider newsletter ◆ Provider education ◆ Member education ◆ Case and care manager training ◆ Medical record review ◆ Improved lab data

Table C.2—Quality Improvement Project Validation Activity
AIDS Healthcare Foundation—Los Angeles County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Internal QIPs				
Advance Care Directives	Annual Submission	93%	100%	*Met*
CD4 and Viral Load Testing	Annual Submission	85%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.3—Quality Improvement Project Average Rates*
AIDS Healthcare Foundation—Los Angeles County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	94%	0%	6%
	VIII: Appropriate Improvement Strategies	67%	33%	0%
Implementation Total		**86%**	**9%**	**5%**
Outcomes	IX: Real Improvement Achieved	63%	0%	38%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total**		**63%**	**0%**	**38%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

Table C.4—Quality Improvement Project Outcomes
AIDS Healthcare Foundation—Los Angeles County
July 1, 2012, through June 30, 2013

QIP #1—Advance Care Directives			
Study Indicator 1: Percentage of eligible members that have an advance directive or have had a discussion regarding advanced directives with their provider			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
7.2%	25.7%*	‡	‡

QIP #2—CD4 and Viral Load Testing			
Study Indicator 1: Percentage of eligible members receiving at least three CD4 lab tests			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
69.3%	69.7%	63.8%	‡
Study Indicator 2: Percentage of eligible members receiving at least three Viral Load lab tests			
Baseline Period 1/1/11–12/31/11	**Remeasurement 1 1/1/12–12/31/12**	**Remeasurement 2 1/1/13–12/31/13**	**Sustained Improvement¥**
68.9%	73.4%	65.7%*	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

**Table C.5—Quality Improvement Project Domain(s) of Care and Interventions
Alameda Alliance for Health—Alameda County
July 1, 2012, through June 30, 2013**

QIP #1—Improving Anti-Hypertensive Medication Fills Among Members with Hypertension		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Provider education ◆ Interactive voice response calls to members ◆ Case management ◆ Member newsletters ◆ Pharmacy auto-refill enrollment

QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Mobil medical care: Physicians to conduct in-home visits with discharged patients ◆ On-site concurrent review performed by nurses prior to discharge ◆ Pharmacy Reduction Pilot Intervention program

**Table C.6—Quality Improvement Project Validation Activity
Alameda Alliance for Health—Alameda County
July 1, 2012, through June 30, 2013**

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension	Annual Submission	76%	71%	*Partially Met*
	Annual Resubmission 1	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.7—Quality Improvement Project Average Rates*
Alameda Alliance for Health—Alameda County
(Number = 3 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	**I: Appropriate Study Topic**	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	75%	25%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection**	83%	8%	8%
Design Total		**88%**	**9%**	**3%**
Implementation	**VII: Sufficient Data Analysis and Interpretation****	88%	0%	13%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**92%**	**0%**	**8%**
Outcomes	**IX: Real Improvement Achieved**	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

Table C.8—Quality Improvement Project Domain(s) of Care and Interventions
Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties
July 1, 2012, through June 30, 2013

QIP #1—Improving HEDIS Postpartum Care Rates			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Alameda, Contra Costa, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare	Q, A	◆ Member education ◆ Member reminder mailings and calls ◆ Member incentive gift ◆ Distribution of provider toolkits ◆ Distribution of transportation information
QIP #2—Improving Diabetes Management			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Alameda and Contra Costa	Q, A	◆ This QIP was in the Design stage; therefore, no interventions were submitted.
QIP #3—All-Cause Readmissions			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	All	Q, A	◆ Member education and counseling programs ◆ Implement transition of care programs ◆ Address cultural and linguistic needs in discharge planning instructions ◆ Help members find appropriate providers ◆ Solve transportation issues ◆ Provide community resources information

Table C.9—Quality Improvement Project Validation Activity
Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties
July 1, 2012, through June 30, 2013

Name of Project/Study	Counties	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	Counties received the same score—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare	Study Design Submission	80%	100%	*Met*
Internal QIPs					
Improving HEDIS Postpartum Care Rates	Alameda	Annual Submission	97%	100%	*Met*
	Contra Costa	Annual Submission	100%	100%	*Met*
	Sacramento	Annual Submission	94%	100%	*Met*
	San Francisco	Annual Submission	93%	100%	*Met*
	San Joaquin	Annual Submission	91%	100%	*Met*
	Santa Clara	Annual Submission	94%	100%	*Met*
	Stanislaus	Annual Submission	94%	100%	*Met*
	Tulare	Annual Submission	94%	100%	*Met*
Improving Diabetes Management	Counties received the same score—Alameda and Contra Costa	Study Design Submission	64%	67%	*Not Met*
		Study Design Resubmission 1	80%	67%	*Partially Met*
		Study Design Resubmission 2	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.10—Quality Improvement Project Average Rates*
Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties
(Number = 5 QIP Submissions, 3 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	84%	16%	0%
	V: Valid Sampling Techniques (if sampling is used)	96%	0%	4%
	VI: Accurate/Complete Data Collection**	75%	5%	21%
Design Total**		**88%**	**3%**	**8%**
Implementation	VII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	IX: Real Improvement Achieved**	63%	0%	38%
	X: Sustained Improvement Achieved	50%	0%	50%
Outcomes Total		**61%**	**0%**	**39%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

Table C.11—Quality Improvement Project Outcomes for Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties
July 1, 2012, through June 30, 2013

QIP #1—Improving HEDIS Postpartum Care Rates				
Study Indicator: Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery				
County	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
Alameda	43.3%	51.1%*	50.6%	Yes
Contra Costa	28.8%	43.6%*	48.2%	Yes
Sacramento	52.1%	49.9%	54.3%	‡
San Francisco	57.4%	55.5%	64.0%	‡
San Joaquin	48.9%	51.3%	48.2%	‡
Santa Clara	55.5%	65.7%*	60.6%	No
Stanislaus	54.3%	53.7%	56.7%	‡
Tulare	46.5%	64.0%*	53.1%*	No

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Table C.12—Quality Improvement Project Domain(s) of Care and Interventions
CalOptima—Orange County
July 1, 2012, through June 30, 2013

QIP #1—Improving the Rates of Cervical Cancer Screening		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q	◆ Healthy women campaign ◆ Member education ◆ Provider outreach ◆ Member reminder cards ◆ Cervical cancer screening office staff incentive ◆ Member incentives ◆ Provider incentives ◆ Newsletters/articles ◆ Telephone outreach
QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Transitions of Care program ◆ Mailing discharge kits

Table C.13—Quality Improvement Project Validation Activity
CalOptima—Orange County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Improving the Rates of Cervical Cancer Screening	Annual Submission	86%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not* Met.

Table C.14—Quality Improvement Project Average Rates*
CalOptima—Orange County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity		Met Elements	Partially Met Elements	Not Met Elements
Design	I:	Appropriate Study Topic	100%	0%	0%
	II:	Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III:	Clearly Defined Study Indicator(s)	100%	0%	0%
	IV:	Correctly Identified Study Population	100%	0%	0%
	V:	Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI:	Accurate/Complete Data Collection	78%	11%	11%
Design Total**			**93%**	**4%**	**4%**
Implementation	VII:	Sufficient Data Analysis and Interpretation	89%	11%	0%
	VIII:	Appropriate Improvement Strategies	100%	0%	0%
Implementation Total			**92%**	**8%**	**0%**
Outcomes	IX:	Real Improvement Achieved	25%	50%	25%
	X:	Sustained Improvement Achieved	100%	0%	0%
Outcomes Total			**40%**	**40%**	**20%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

Table C.15—Quality Improvement Project Outcomes for CalOptima—Orange County
July 1, 2012, through June 30, 2013

QIP #1—Improving the Rates of Cervical Cancer Screening			
Study Indicator 1: Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer during the measurement year or two years prior			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
71.7%	75.5%	72.0%	‡
Study Indicator 2: Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer during the measurement year or two years prior who were assigned to the top 200 high volume providers			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
69.6%	71.0%*	71.1%	Yes

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Table C.16—Quality Improvement Project Domain(s) of Care and Interventions
CalViva Health—Fresno, Kings, and Madera Counties
July 1, 2012, through June 30, 2013

QIP #1—Retinal Eye Exam		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ This QIP was in the Design stage; therefore, no interventions were submitted.
QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Ambulatory case management ◆ Health plan on-site case managers ◆ Distribute Agency for Healthcare Research and Quality brochure: *Taking Care of Myself: A Guide for When I Leave the Hospital* ◆ Implement My Health Direct program: electronic appointment scheduling system

Table C.17—Quality Improvement Project Validation Activity
CalViva Health—Fresno, Kings, and Madera Counties
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	89%	100%	*Met*
Internal QIPs				
Retinal Eye Exams	Study Design Submission	75%	83%	*Not Met*
	Study Design Resubmission 1	90%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.18—Quality Improvement Project Average Rates*
CalViva Health—Fresno, Kings, and Madera Counties
(Number = 3 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	62%	15%	23%
Design Total		**84%**	**6%**	**10%**
Implementation	VII: Sufficient Data Analysis and Interpretation	Not Assessed	Not Assessed	Not Assessed
	VIII: Appropriate Improvement Strategies	Not Assessed	Not Assessed	Not Assessed
Implementation Total		**0%**	**0%**	**0%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.19—Quality Improvement Project Domain(s) of Care and Interventions
Care1st Partner Plan—San Diego County
July 1, 2012, through June 30, 2013

QIP #1—Comprehensive Diabetic Care		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Quality Outreach program: Building relationships with members and educating them on disease process ◆ Ensuring members receive comprehensive care across departments ◆ Web portal enhancements and outreach ◆ Provider incentives ◆ Proactive diabetic tracking database and process ◆ Utilization of home health visits

QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Discharge planning interventions: ▪ Hospitalist and in-house case management on-site ▪ Case management and discharge planning ▪ Case manager assigned ▪ Follow-up visits with primary care physician within seven days ▪ Medication reconciliation ◆ Reminder calls ◆ Free transportation

Table C.20—Quality Improvement Project Validation Activity
Care1st Partner Plan—San Diego County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	60%	60%	*Partially Met*
	Study Design Resubmission 1	100%	100%	*Met*
Internal QIPs				
Comprehensive Diabetic Care	Annual Submission	26%	10%	*Not Met*
	Annual Resubmission 1	64%	88%	*Not Met*
	Annual Resubmission 2	89%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.21—Quality Improvement Project Average Rates*
Care1st Partner Plan—San Diego County
(Number = 5 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	90%	10%	0%
	II: Clearly Defined, Answerable Study Question(s)	80%	20%	0%
	III: Clearly Defined Study Indicator(s)	60%	40%	0%
	IV: Correctly Identified Study Population	80%	20%	0%
	V: Valid Sampling Techniques (if sampling is used)	0%	0%	100%
	VI: Accurate/Complete Data Collection	62%	15%	23%
Design Total		**63%**	**18%**	**19%**
Implementation	VII: Sufficient Data Analysis and Interpretation	68%	16%	16%
	VIII: Appropriate Improvement Strategies	75%	25%	0%
Implementation Total		**70%**	**19%**	**11%**
Outcomes	IX: Real Improvement Achieved	25%	25%	50%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**25%**	**25%**	**50%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.22—Quality Improvement Project Outcomes
Care1st Partner Plan—San Diego County
July 1, 2012, through June 30, 2013

QIP #1			
Study Indicator 1: The percentage of diabetic members 18-75 years of age who received at least one HgbA1c screening test			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
83.6%	88.8%	‡	‡
Study Indicator 2: The percentage of diabetic members 18-75 years of age with an HgbA1c result of >9 (poor control) or no HbA1c screening test^			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
30.9%	37.0%	‡	‡
Study Indicator 3: The percentage of diabetic members 18-75 years of age who received an LDL screening test			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
80.6%	81.5%	‡	‡
Study Indicator 4: The percentage of diabetic members 18-75 years of age who received a retinal eye exam			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
41.8%	47.4%	‡	‡
Study Indicator 5: The percentage of diabetic members 18-75 years of age who received a nephropathy screening test			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
87.3%	88.4%	‡	‡

^A lower percentage indicates better performance.

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Table C.23—Quality Improvement Project Domain(s) of Care and Interventions
CenCal Health—San Luis Obispo and Santa Barbara Counties
July 1, 2012, through June 30, 2013

QIP #1—Weight Assessment and Counseling for Nutrition and Physical Activity for Children & Adolescents		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q	◆ Provider education ◆ Childhood Obesity Summit Outreach program ◆ Member education ◆ Member mailings
QIP #2—Annual Monitoring for Patients on Persistent Medications		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q	◆ This QIP was in the Design stage; therefore, no interventions were submitted.
QIP #3—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Developed hospital census process to identify patients being discharged ◆ High- and low-risk criteria established to perform targeted interventions ◆ Pay-for-Performance for providers ◆ Provider to perform outreach program with patients ◆ Provider notifications of patients being discharged

Table C.24—Quality Improvement Project Validation Activity
CenCal Health—San Luis Obispo and Santa Barbara Counties
July 1, 2012, through June 30, 2013

Name of Project/Study	County	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	Counties received the same score—San Luis Obispo and Santa Barbara	Study Design Submission	100%	100%	*Met*
Internal QIPs					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children & Adolescents	San Luis Obispo	Annual Submission	100%	100%	*Met*
	Santa Barbara	Annual Submission	97%	100%	*Met*
Annual Monitoring for Patients on Persistent Medications	Counties received the same score—San Luis Obispo and Santa Barbara	Study Design Submission	70%	100%	*Partially Met*
	Counties received the same score—San Luis Obispo and Santa Barbara	Study Design Resubmission 1	90%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.25—Quality Improvement Project Average Rates*
CenCal Health—San Luis Obispo and Santa Barbara Counties
(Number = 4 QIP Submissions, 3 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	**I: Appropriate Study Topic**	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	78%	0%	22%
Design Total		**92%**	**0%**	**8%**
Implementation	**VII: Sufficient Data Analysis and Interpretation**	100%	0%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	**IX: Real Improvement Achieved****	88%	13%	0%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**90%**	**10%**	**0%**

***The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.**

****The stage and/or activity totals may not equal 100 percent due to rounding.

Table C.26—Quality Improvement Project Outcomes
CenCal Health—San Luis Obispo and Santa Barbara Counties
July 1, 2012, through June 30, 2013

QIP #1—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents					
Study Indicator 1: Percentage of members 3 to 17 years of age who had a BMI percentile documented					
County	**Baseline Period 1/1/08–12/31/08**	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Remeasurement 3 1/1/11–12/31/11**	**Sustained Improvement¥**
San Luis Obispo	NR	33.2%	47.0%*	62.3%*	Yes
Santa Barbara	37.5%	55.0%*	59.1%	66.4%*	Yes
Study Indicator 2: Percentage of members 3 to 17 years of age who had a documentation or referral for nutrition education					
County	**Baseline Period 1/1/08–12/31/08**	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Remeasurement 3 1/1/11–12/31/11**	**Sustained Improvement¥**
San Luis Obispo	NR	50.8%	57.9%*	59.6%	Yes
Santa Barbara	44.7%	65.9%*	72.5%*	67.9%	Yes
Study Indicator 3: Percentage of members 3 to 17 years of age who had a documentation or a referral for physical activity counseling					
County	**Baseline Period 1/1/08–12/31/08**	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Remeasurement 3 1/1/11–12/31/11**	**Sustained Improvement¥**
San Luis Obispo	NR	20.0%	34.8%*	47.7%*	Yes
Santa Barbara	9.7%	11.6%	39.2%*	44.8%	Yes

NR—San Luis Obispo's baseline data corresponds to the same time period as Santa Barbara's Remeasurement 1 data.

¥ Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Note: This QIP was initiated prior to HSAG implementing its new scoring methodology that requires statistically significant improvement over baseline; therefore, the previous definition of sustained improvement was used.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

Table C.27—Quality Improvement Project Domain(s) of Care and Interventions
Central California Alliance for Health—Merced and Santa Cruz/Monterey Counties
July 1, 2012, through June 30, 2013

QIP #1—Improving Asthma Health Outcomes		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ This QIP was in the Design stage; therefore, no interventions were submitted.

QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Notification of patient's admission to hospital ◆ Implement Transitional Care program for members identified as high-risk for readmissions and will include an assessment of discharge plans and needs, offering additional support for 30 days, and referral to Care Management, if needed ◆ Implement Transition of Care pilot program, for members at higher risk for readmissions based on specific diagnoses, including a home visit by a nurse, medication reconciliation, and coordination of follow-up visits

Table C.28—Quality Improvement Project Validation Activity
Central California Alliance for Health—Merced and Santa Cruz/Monterey Counties
July 1, 2012, through June 30, 2013

Name of Project/Study	County	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	Counties received the same score—Merced and Santa Cruz/ Monterey	Study Design Submission	90%	100%	*Met*
Internal QIPs					
Improving Asthma Health Outcomes	Counties received the same score—Merced and Santa Cruz/ Monterey	Study Design Submission	45%	0%	*Not Met*
	Counties received the same score—Merced and Santa Cruz/ Monterey	Study Design Resubmission 1	59%	43%	*Not Met*
	Counties received the same score—Merced and Santa Cruz/ Monterey	Study Design Resubmission 2	55%	40%	*Not Met*
	Counties received the same score—Merced and Santa Cruz/ Monterey	Study Design Resubmission 3	91%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.29—Quality Improvement Project Average Rates*
Central California Alliance for Health—Merced and Santa Cruz/Monterey Counties
(Number = 5 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	80%	20%	0%
	II: Clearly Defined, Answerable Study Question(s)	80%	20%	0%
	III: Clearly Defined Study Indicator(s)	64%	36%	0%
	IV: Correctly Identified Study Population	40%	60%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	80%	15%	5%
Design Total		**72%**	**26%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	25%	25%	50%
	VIII: Appropriate Improvement Strategies	0%	0%	100%
Implementation Total**		**17%**	**17%**	**67%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

Table C.30—Quality Improvement Project Domain(s) of Care and Interventions
Community Health Group Partnership Plan—San Diego County
July 1, 2012, through June 30, 2013

QIP #1—Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q	◆ Case management calls to high-risk patients ◆ Specialized health education ◆ Provider newsletter ◆ Review/update of clinical guidelines ◆ Annual member mailing ◆ Provider reminder to schedule visits with members
QIP #2—Increasing Screening for Postpartum Depression		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, T	◆ Provider postpartum exam incentive ◆ Provider newsletter ◆ Provider educational materials ◆ Member educational materials ◆ Evaluations by Clinical Quality Improvement and Utilization Management committees ◆ Medical record review
QIP #3—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Pharmacy to deliver medications ◆ Home health nurse visits ◆ Case manager follow-up

Table C.31—Quality Improvement Project Validation Activity
Community Health Group Partnership Plan—San Diego County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Small-Group Collaborative				
Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD	Annual Submission	78%	86%	*Partially Met*
	Annual Resubmission 1	85%	100%	*Met*
Internal QIPs				
Increasing Screens for Postpartum Depression	Annual Submission	95%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.32—Quality Improvement Project Average Rates*
Community Health Group Partnership Plan—San Diego County
(Number = 4 QIP Submissions, 3 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	94%	0%	6%
Design Total		**98%**	**0%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	88%	12%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**92%**	**8%**	**0%**
Outcomes	IX: Real Improvement Achieved	33%	67%	0%
	X: Sustained Improvement Achieved	67%	33%	0%
Outcomes Total		**40%**	**60%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.33—Quality Improvement Project Outcomes
Community Health Group Partnership Plan—San Diego County
July 1, 2012, through June 30, 2013

QIP #1—Increasing Assessment, Diagnosis, and Appropriate Treatment of COPD

Study Indicator 1: Percentage of members 40 years and older with a new diagnosis of newly active COPD who received appropriate Spirometry testing to confirm the diagnosis

Baseline Period 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Remeasurement 2 1/1/09–12/31/09	Remeasurement 3 1/1/10–12/31/10	Remeasurement 4 1/1/11–12/31/11	Sustained Improvement¥
11.4%	19.5%	11.1%	19.1%	20.7%	‡

Study Indicator 2: Percentage of acute inpatient hospitalization discharges of members with COPD^

Baseline Period 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Remeasurement 2 1/1/09–12/31/09	Remeasurement 3 1/1/10–12/31/10	Remeasurement 4 1/1/11–12/31/11	Sustained Improvement¥
54.9%	68.8%*	23.5%*	8.3%*	14.2%*	Yes

Study Indicator 3: Percentage of emergency department (ED) visits for members with COPD^

Baseline Period 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Remeasurement 2 1/1/09–12/31/09	Remeasurement 3 1/1/10–12/31/10	Remeasurement 4 1/1/11–12/31/11	Sustained Improvement¥
69.0%	70.5%	30.3%*	20.0%*	19.3%	Yes

Study Indicator 4a: Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter who were dispensed Systemic cortico-steroid within 14 days of the event

Baseline Period 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Remeasurement 2 1/1/09–12/31/09	Remeasurement 3 1/1/10–12/31/10	Remeasurement 4 1/1/11–12/31/11	Sustained Improvement¥
52.5%	41.1%	45.3%	55.6%	58.3%	‡

Study Indicator 4b: Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter who were dispensed Broncho-dilator within 30 days of the event

Baseline Period 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Remeasurement 2 1/1/09–12/31/09	Remeasurement 3 1/1/10–12/31/10	Remeasurement 4 1/1/11–12/31/11	Sustained Improvement¥
75.0%	68.9%	60.0%	69.4%	85.0%	‡

QIP #2—Increasing Screening for Postpartum Depression

Study Indicator 1: Percentage of members who had a live birth and were screened for depression at their postpartum visit

Baseline Period 11/6/06–11/5/07	Remeasurement 1 11/6/07–11/5/08	Remeasurement 2 11/6/08–11/5/09	Remeasurement 2 11/6/09–11/5/10	Remeasurement 2 11/6/10–11/5/11	Sustained Improvement¥
23.1%	34.3%*	32.4%	43.3%*	48.2%	Yes

Study Indicator 2: Percentage of members who were screened for postpartum depression through the use of a screening tool

Baseline Period 11/6/06–11/5/07	Remeasurement 1 11/6/07–11/5/08	Remeasurement 2 11/6/08–11/5/09	Remeasurement 2 11/6/09–11/5/10	Remeasurement 2 11/6/10–11/5/11	Sustained Improvement¥
9.5%	19.2%*	17.3%	21.9%	26.3%	Yes

Study Indicator 2: Percentage of members with a positive screen for postpartum depression and documentation of follow-up care

Baseline Period 11/6/06–11/5/07	Remeasurement 1 11/6/07–11/5/08	Remeasurement 2 11/6/08–11/5/09	Remeasurement 2 11/6/09–11/5/10	Remeasurement 2 11/6/10–11/5/11	Sustained Improvement¥
63.6%	85.7%	81.3%	88.5%	90.6%	‡

^A lower percentage indicates better performance.

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Table C.34—Quality Improvement Project Domain(s) of Care and Interventions
Contra Costa Health Plan—Contra Costa County
July 1, 2012, through June 30, 2013

QIP #1—Reducing Childhood Obesity		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Technical assistance for providers ◆ Revision of well-child forms and billing procedures ◆ Member satisfaction survey ◆ Member Weight Management toolkit ◆ Training for providers and nurses
QIP #2—Improving Perinatal Access and Care		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A, T	◆ This QIP was in the Design stage; therefore, no interventions were submitted.
QIP #3—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Establish Care Transitions Initiative ◆ Instituted Telephone Consultation Clinic for members ◆ Establish call center ◆ Nurses perform follow-up calls within 48 hours of discharge ◆ Promotion of 24-hour Nurse Advice Line

Table C.35—Quality Improvement Project Validation Activity
Contra Costa Health Plan—Contra Costa County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	70%	100%	*Partially Met*
	Study Design Resubmission 1	90%	100%	*Met*
Internal QIPs				
Reducing Childhood Obesity	Annual Submission	89%	100%	*Met*
Improving Perinatal Access and Care	Study Design Submission	44%	43%	*Not Met*
	Study Design Resubmission 1	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.36—Quality Improvement Project Average Rates*
Contra Costa Health Plan—Contra Costa County
(Number = 5 QIP Submissions, 3 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	80%	20%	0%
	III: Clearly Defined Study Indicator(s)	90%	10%	0%
	IV: Correctly Identified Study Population	80%	20%	0%
	V: Valid Sampling Techniques (if sampling is used)	94%	0%	6%
	VI: Accurate/Complete Data Collection	62%	12%	27%
Design Total		**81%**	**8%**	**11%**
Implementation	VII: Sufficient Data Analysis and Interpretation	89%	11%	0%
	VIII: Appropriate Improvement Strategies	67%	33%	0%
Implementation Total		**83%**	**17%**	**0%**
Outcomes	IX: Real Improvement Achieved	75%	0%	25%
	X: Sustained Improvement Achieved	0%	100%	0%
Outcomes Total		**60%**	**20%**	**20%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.37—Quality Improvement Project Outcomes
Contra Costa Health Plan—Contra Costa County
July 1, 2012, through June 30, 2013

QIP #1—Reducing Childhood Obesity			
Study Indicator 1: Percentage of members 3 to 11 years of age who had a BMI percentile documented in their medical record			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
17.7%¥	66.6%*	61.4%**	Yes
Study Indicator 2: Percentage of members 3 to 11 years of age who had documentation for nutrition counseling in their medical record			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
51.6%	65.3%*	57.4%	No
Study Indicator 3: Percentage of members 3 to 11 years of age who had documentation for physical fitness counseling in their medical record			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
36.3%	50.5%*	47.1%	Yes

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

** A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

Table C.38—Quality Improvement Project Domain(s) of Care and Interventions
Family Mosaic Project—San Francisco County
July 1, 2012, through June 30, 2013

QIP #1—Increase the Rate of School Attendance		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Nonclinical	Q	◆ Perform educational testing on members to diagnose learning disabilities ◆ Identify member's learning style and capacity to learn in order to develop an individualized education plan
QIP #2—Reduction of Out-of-Home Placement		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q	◆ Care manager will convene a Child/Family/Provider Treatment Team ◆ New members will meet with the psychiatrist

Table C.39—Quality Improvement Project Validation Activity
Family Mosaic Project—San Francisco County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Internal QIPs				
Increase the Rate of School Attendance	Annual Submission	81%	100%	*Met*
Reduction of Out-of-Home Placement	Annual Submission	72%	100%	*Partially Met*
	Annual Resubmission 1	80%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.40—Quality Improvement Project Average Rates*
Family Mosaic Project—San Francisco County
(Number = 3 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	90%	10%	0%
Design Total		**97%**	**3%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	58%	29%	13%
	VIII: Appropriate Improvement Strategies	78%	22%	0%
Implementation Total		**64%**	**27%**	**9%**
Outcomes	IX: Real Improvement Achieved	67%	0%	33%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**67%**	**0%**	**33%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.41—Quality Improvement Project Outcomes
Family Mosaic Project—San Francisco County
July 1, 2012, through June 30, 2013

QIP #1—Increase the Rate of School Attendance			
Study Indicator 1: Percentage of 6 month and discharge CANS assessments scored “2” or “3” for members 6-18 years of age^			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
61.8%	35.7%*	‡	‡

QIP #2—Reduction of Out-of-Home Placement			
Study Indicator 2: Percentage of members who are discharged to out-of-home placement^			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
13.6%	12.2%	6.3%	‡

^A lower rate indicates better performance.

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Table C.42—Quality Improvement Project Domain(s) of Care and Interventions
Gold Coast Health Plan—Ventura County
July 1, 2012, through June 30, 2013

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Gold Coast staff follow-up with members within 24–72 hours after discharge to: ▪ Discuss follow-up appointments ▪ Discuss discharge instructions ▪ Discuss prescriptions and how medications are taken ▪ Send additional educational materials

Table C.43—Quality Improvement Project Validation Activity
Gold Coast Health Plan—Ventura County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	80%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.44—Quality Improvement Project Average Rates*
Gold Coast Health Plan—Ventura County
(Number = 1 QIP Submissions, 1 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	50%	25%	25%
Design Total		**80%**	**10%**	**10%**
Implementation	VII: Sufficient Data Analysis and Interpretation	Not Assessed	Not Assessed	Not Assessed
	VIII: Appropriate Improvement Strategies	Not Assessed	Not Assessed	Not Assessed
Implementation Total		**0%**	**0%**	**0%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.45—Quality Improvement Project Domain(s) of Care and Interventions Health Net Community Solutions, Inc.—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties July 1, 2012, through June 30, 2013

QIP #1—Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities (SPD)		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Provider newsletter ◆ Interactive voice response calls to members ◆ Member outreach programs ◆ Member incentive programs
QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Survey hospital primary provider group and primary care physician to assess the lack of transition of care process ◆ Develop initiatives to address specific gaps based on survey results ◆ Distribute *Taking Care of Myself: A Guide for When I Leave the Hospital* ◆ Initiate disease-specific education

Table C.46—Quality Improvement Project Validation Activity
Health Net Community Solutions, Inc.—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties
July 1, 2012, through June 30, 2013

Name of Project/Study	Counties	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	Counties received the same score—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare	Study Design Submission	89%	100%	*Met*
Internal QIPs					
Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities	Kern	Annual Submission	89%	100%	*Met*
	Los Angeles	Annual Submission	85%	100%	*Met*
	Sacramento	Annual Submission	89%	100%	*Met*
	San Diego	Annual Submission	85%	100%	*Met*
	Stanislaus	Annual Submission	88%	100%	*Met*
	Tulare	Annual Submission	88%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.47—Quality Improvement Project Average Rates*
Health Net Community Solutions, Inc.—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	86%	14%	0%
Design Total		**95%**	**5%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	VIII: Appropriate Improvement Strategies	80%	10%	10%
Implementation Total		**94%**	**3%**	**3%**
Outcomes	IX: Real Improvement Achieved	33%	0%	67%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**33%**	**0%**	**67%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.48—Quality Improvement Project Outcomes
Health Net Community Solutions, Inc.—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties
July 1, 2012, through June 30, 2013

QIP #1—Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities (SPD)				
Study Indicator: The percentage of SPD women who received one or more Pap tests during the measurement year or the two prior years				
County	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
Kern	40.9%	41.5%	42.0%	‡
Los Angeles	50.8%	50.5%	49.8%	‡
Sacramento	39.6%	37.4%	39.8%	‡
San Diego	42.1%	43.4%	41.1%	‡
Stanislaus	44.7%	47.9%	45.6%	‡
Tulare	40.6%	46.5%	45.6%	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Table C.49—Quality Improvement Project Domain(s) of Care and Interventions
Health Plan of San Joaquin—San Joaquin County
July 1, 2012, through June 30, 2013

QIP #1—Improve the Percentage of HbA1C Testing		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Provider incentives ◆ Educational in-service to Medical Management Department ◆ Case management outreach program ◆ Provider education ◆ Member education ◆ Increase staff

QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Patient outreach program: Patient Centered Medical Home ◆ Hospital emergency room and social workers outreach program ◆ Information technology upgrade to expand complex case management and disease management programs ◆ Doctors and nurses to make home visits ◆ Extended on-call hours ◆ Initial health assessment for all new members ◆ Increase staff

Table C.50—Quality Improvement Project Validation Activity
Health Plan of San Joaquin—San Joaquin County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Improving the Percentage Rate of HbA1c Testing	Annual Submission	94%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.51—Quality Improvement Project Average Rates*
Health Plan of San Joaquin—San Joaquin County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	90%	0%	10%
Design Total		**96%**	**0%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	IX: Real Improvement Achieved	50%	0%	50%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**50%**	**0%**	**50%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.52—Quality Improvement Project Outcomes
Health Plan of San Joaquin—San Joaquin County
July 1, 2012, through June 30, 2013

QIP #1—Improving the Percentage of HbA1c Testing			
Study Indicator: Percentage of diabetic members with at least one HbA1c test			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement[¥]**
80.5%	81.5%	‡	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Table C.53—Quality Improvement Project Domain(s) of Care and Interventions
Health Plan of San Mateo—San Mateo County
July 1, 2012, through June 30, 2013

QIP #1—Increasing Timeliness of Prenatal Care		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A, T	◆ Prenatal Care Incentive Program for members ◆ Member newsletter ◆ Implement Pay-for-Performance provider incentives ◆ Implement social marketing campaign, "Go Before You Show"
QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Care coordination technicians will call seniors and persons with disabilities members after discharge and set up appointment with primary care physician ◆ Send mail notification to all members regarding the importance of follow-up primary care physician visits ◆ Notify primary care physician of members' admissions ◆ Send providers quarterly reports on their patients' readmission rates

Table C.54—Quality Improvement Project Validation Activity
Health Plan of San Mateo—San Mateo County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	80%	100%	*Met*
Internal QIPs				
Increasing Timeliness of Prenatal Care	Annual Submission	91%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.55—Quality Improvement Project Average Rates*
Health Plan of San Mateo—San Mateo County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	80%	10%	10%
Design Total**		**93%**	**4%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**25%**	**0%**	**75%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

Table C.56—Quality Improvement Project Outcomes
Health Plan of San Mateo—San Mateo County
July 1, 2012, through June 30, 2013

QIP #1—Increasing Timeliness of Prenatal Care			
Study Indicator: Percentage of members that had a prenatal care visit in the first trimester or within 42 days of enrollment			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
85.3%	83.2%	81.9%	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Table C.57—Quality Improvement Project Domain(s) of Care and Interventions
Inland Empire Health Plan—San Bernardino/Riverside County
July 1, 2012, through June 30, 2013

QIP #1—Attention Deficit Hyperactivity Disorder (ADHD) Management		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Provider education ◆ Implemented a Behavioral Health Department ◆ Meetings with school nurses regarding ADHD management, preventive care, and safety issues and concerns
QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Primary care physician fax notifications ◆ Hospital-based interventions: ▪ Provide in-hospital visit and a home visit ▪ Provide in-hospital visit and a follow-up call ◆ Develop and implement Transitions of Care Program ◆ Behavioral health staff involvement in care management ◆ "Know My Meds" portal available to staff and contracted providers

Table C.58—Quality Improvement Project Validation Activity
Inland Empire Health Plan—San Bernardino/Riverside County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	80%	100%	*Met*
Internal QIPs				
Attention Deficit Hyperactivity Disorder (ADHD) Management	Annual Submission	84%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.59—Quality Improvement Project Average Rates*
Inland Empire Health Plan—San Bernardino/Riverside County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	75%	13%	13%
Design Total		**90%**	**5%**	**5%**
Implementation	VII: Sufficient Data Analysis and Interpretation	88%	13%	0%
	VIII: Appropriate Improvement Strategies	67%	33%	0%
Implementation Total		**82%**	**18%**	**0%**
Outcomes	IX: Real Improvement Achieved	50%	50%	0%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**50%**	**50%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.60—Quality Improvement Project Outcomes
Inland Empire Health Plan—San Bernardino/Riverside County
July 1, 2012, through June 30, 2013

QIP #1—Attention Deficit Hyperactivity Disorder (ADHD) Management			
Study Indicator 1: The percentage of eligible members who had an outpatient follow-up visit within 30 days after the Index Prescription Start Date			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
17.7%	19.3%	22.3%*	‡
Study Indicator 2: The percentage of eligible members with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
17.0%	15.2%	21.4%**	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference between the measurement period and the baseline period (p value < 0.05).

** A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

**Table C.61—Quality Improvement Project Domain(s) of Care and Interventions
Kaiser–Sacramento County
July 1, 2012, through June 30, 2013**

QIP #1—Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Provider training ◆ Enhancement of electronic medical record computer software ◆ Implemented “Get Healthy Action Plan”
QIP #2—Childhood Immunization Status (CIS)		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A, T	◆ This QIP was in the Design stage; therefore, no interventions were submitted.
QIP #3—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Transition care pharmacist to conduct medication reconciliations and bedside patient education ◆ Pre-booked follow-up appointment for adult services patients prior to discharge ◆ High-risk patients receive telephone calls within 48 hours

Table C.62—Quality Improvement Project Validation Activity
Kaiser–Sacramento County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents	Annual Submission	100%	100%	*Met*
Childhood Immunization Status (CIS)	Study Design Submission	82%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.63—Quality Improvement Project Average Rates*
Kaiser–Sacramento County
(Number = 3 QIP Submissions, 3 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	75%	25%	0%
Design Total		**90%**	**10%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**100%**	**0%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.64—Quality Improvement Project Outcomes
Kaiser–Sacramento County
July 1, 2012, through June 30, 2013

QIP #1—Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents			
Study Indicator 1: Percentage of members 3–17 years of age who had an outpatient visit with a primary care provider and who had evidence of BMI percentile documentation in the medical record			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
38.1%	52.8%*	73.5%**	Yes
Study Indicator 2: Percentage of members 3–17 years of age with documentation in the medical record of counseling for nutrition during the measurement year			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
46.7%	60.3%*	75.9%**	Yes
Study Indicator 3: Percentage of members 3–17 years of age with documentation in the medical record of counseling for physical activity during the measurement year			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
24.5%	59.8%*	75.6%**	Yes

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

** A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

Table C.65—Quality Improvement Project Domain(s) of Care and Interventions
Kaiser–San Diego County
July 1, 2012, through June 30, 2013

QIP #1— Children and Adolescents' Access to Primary Care Practitioners		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Provide evening appointments ◆ Member education ◆ Provider education ◆ New Clinical Strategic Goal established
QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Establish Bridge Clinic pilot: Program to help support the patient after release from hospital ◆ Home health visit within 24 hours of discharge ◆ Pharmacy to contact patient if prescription is not picked up

Table C.66—Quality Improvement Project Validation Activity
Kaiser–San Diego County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Children and Adolescents' Access to Primary Care Practitioners (PCP)	Annual Submission	44%	71%	*Not Met*
	Annual Resubmission 1	56%	71%	*Not Met*
	Annual Resubmission 2	81%	71%	*Partially Met*
	Annual Resubmission 3	88%	86%	*Partially Met*
	Annual Resubmission 4	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.67—Quality Improvement Project Average Rates*
Kaiser–San Diego County
(Number = 6 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	75%	21%	4%
Design Total		**90%**	**8%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	60%	20%	20%
	VIII: Appropriate Improvement Strategies	20%	40%	40%
Implementation Total**		**47%**	**27%**	**27%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

**Table C.68—Quality Improvement Project Domain(s) of Care and Interventions
Kern Family Health Care—Kern County
July 1, 2012, through June 30, 2013**

QIP #1—Comprehensive Diabetic Quality Improvement Plan		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Member education ◆ Provider education ◆ Distribute HEDIS results to providers ◆ Pay for Performance provider program ◆ Text Message pilot program
QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Discharge advocate ◆ Health coach ◆ Post Discharge Clinic and Home Visit Program ◆ Medication Therapy Management ◆ Inpatient management groups in the Member Health Summary System

Table C.69—Quality Improvement Project Validation Activity
Kern Family Health Care—Kern County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Comprehensive Diabetic Quality Improvement Plan	Annual Submission	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.70—Quality Improvement Project Average Rates*
Kern Family Health Care—Kern County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	**I: Appropriate Study Topic**	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	90%	10%	0%
Design Total		**96%**	**4%**	**0%**
Implementation	**VII: Sufficient Data Analysis and Interpretation**	100%	0%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	**IX: Real Improvement Achieved**	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.71—Quality Improvement Project Domain(s) of Care and Interventions
L.A. Care Health Plan—Los Angeles County
July 1, 2012, through June 30, 2013

QIP #1—Improving HbA1c and Diabetic Retinal Exam Screening Rates		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Member reminder telephone calls and mailings ◆ Physician Pay-for-Performance program ◆ Diabetes Improvement project ◆ NCQA Diabetes Recognition program ◆ Comprehensive Diabetes Physician Incentive
QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Hospital Data Retrieval Enhancement Intervention ◆ Enhance transition of care team

Table C.72—Quality Improvement Project Validation Activity
L.A. Care Health Plan—Los Angeles County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Improving HbA1c and Diabetic Retinal Exam Screening Rates	Annual Submission	89%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.73—Quality Improvement Project Average Rates*
L.A. Care Health Plan—Los Angeles County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	90%	0%	10%
Design Total		**96%**	**0%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	89%	11%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**92%**	**8%**	**0%**
Outcomes	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**25%**	**0%**	**75%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.74—Quality Improvement Project Outcomes
L.A. Care Health Plan—Los Angeles County
July 1, 2012, through June 30, 2013

QIP #1—Improving HbA1c and Diabetic Retinal Exam Screening Rates			
Study Indicator 1: The percentage of members 18–75 years of age with diabetes who received HbA1c testing as of December 31 of the measurement year			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
82.1%	85.0%	83.8%	‡
Study Indicator 2: The percentage of members 18–75 years of age with diabetes who received a retinal eye exam in the measurement year or a negative retinal eye exam in the year prior to the measurement year			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
52.8%	50.7%	50.7%	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.
‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Table C.75—Quality Improvement Project Domain(s) of Care and Interventions
Molina Healthcare of California Partner Plan, Inc.—Sacramento,
San Bernardino/Riverside, and San Diego Counties
July 1, 2012, through June 30, 2013

QIP #1—Improving Hypertension Control		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Distribute quarterly reports to physicians ◆ Member mailings ◆ Member outreach calls ◆ Provider newsletter ◆ Annual review and adoption of the Hypertension Clinical Practice Guidelines
QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Inpatient review rounds and case management assignment prior to discharge ◆ Member “Welcome Home Call” ◆ Health plan care transition clinicians ◆ Health plan care managers initiate communication with hospital and patient ◆ On-call health plan discharge staff ◆ Provider education ◆ In-home support services ◆ Arrange transportation for members ◆ Member education ◆ Interdisciplinary care team meetings

**Table C.76—Quality Improvement Project Validation Activity
Molina Healthcare of California Partner Plan, Inc.—Sacramento,
San Bernardino/Riverside, and San Diego Counties
July 1, 2012, through June 30, 2013**

Name of Project/Study	Counties	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	Counties received the same score—Sacramento, San Bernardino/Riverside and San Diego	Study Design Submission	90%	100%	*Met*
Internal QIPs					
Improving Hypertension Control	Riverside/San Bernardino	Annual Submission	94%	100%	*Met*
	Sacramento	Annual Submission	94%	100%	*Met*
	San Diego	Annual Submission	91%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.77—Quality Improvement Project Average Rates*
Molina Healthcare of California Partner Plan, Inc.—Sacramento, San Bernardino/Riverside, and San Diego Counties
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	90%	0%	10%
Design Total		**96%**	**0%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	IX: Real Improvement Achieved	42%	0%	58%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**42%**	**0%**	**58%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.78—Quality Improvement Project Outcomes
Molina Healthcare of California Partner Plan, Inc.—Sacramento, San Bernardino/Riverside, and San Diego Counties
July 1, 2012, through June 30, 2013

QIP #1—Improving Hypertension Control				
Study Indicator: Percentage of members 18 to 85 years of age who had both a systolic and diastolic blood pressure of <140/90				
County	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
Riverside/San Bernardino	59.6%	42.6%*	53.7%*	‡
Sacramento	56.6%	50.8%	53.1%	‡
San Diego	66.4%	58.3%*	55.0%	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Table C.79—Quality Improvement Project Domain(s) of Care and Interventions
Partnership HealthPlan of California—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties
July 1, 2012, through June 30, 2013

QIP #1—Improving Care and Reducing Acute Readmissions for People with COPD			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Napa/Solano/ Yolo	A	◆ Development of registry to ensure providers are able to identify COPD patients ◆ Provider education ◆ Distribution of COPD provider toolkit ◆ Member education ◆ Pilot program to encourage office-based spirometry testing
QIP #2—Improving Access to Primary Care for Children and Adolescents			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Marin, Mendocino, Napa/Solano/ Yolo, and Sonoma	A	◆ This QIP was in the Design stage; therefore, no interventions were submitted.
QIP #3—All-Cause Readmissions			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Marin, Mendocino, Napa/Solano/ Yolo, and Sonoma	Q, A	◆ Pay-for-Performance program for providers ◆ Follow-up within 4 days of discharge ◆ Provider education ◆ On-line reports for primary care physicians that show admissions for their patients ◆ Implemented Care Transitions Program

Table C.80—Quality Improvement Project Validation Activity
Partnership HealthPlan of California—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties
July 1, 2012, through June 30, 2013

Name of Project/Study	Counties	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	Counties received the same score—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma	Study Design Submission	90%	100%	*Met*
Internal QIPs					
Improving Care and Reducing Acute Readmissions for People with COPD	Napa/Solano/Yolo	Annual Submission	85%	100%	*Met*
Improving Access to Primary Care for Children and Adolescents	Counties received the same score—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma	Study Design Submission	90%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.81—Quality Improvement Project Average Rates*
Partnership HealthPlan of California—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties
(Number = 3 QIP Submissions, 3 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection**	79%	11%	11%
Design Total**		**91%**	**4%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	88%	13%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**92%**	**8%**	**0%**
Outcomes	IX: Real Improvement Achieved	25%	50%	25%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**40%**	**40%**	**20%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

Table C.82—Quality Improvement Project Outcomes
Partnership HealthPlan of California—Napa/Solano/Yolo Counties
July 1, 2012, through June 30, 2013

QIP #1—Improving Care and Reducing Acute Readmissions for People with COPD				
Study Indicator 1: Percentage of members 40 years of age and older with at least one claim/encounter for Spirometry in the 730 days before the Index Episode Start Date to 180 days after the IESD				
Baseline Period 1/1/08–12/31/08	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Remeasurement 3 1/1/11–12/31/11**	**Sustained Improvement¥**
21.4%	23.6%	29.4%	27.5%	‡
Study Indicator 2a: Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter who were dispensed systemic corticosteroid within 14 days of the event				
Baseline Period 1/1/08–12/31/08	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Remeasurement 3 1/1/11–12/31/11**	**Sustained Improvement¥**
37.6%	66.7%*	73.5%	56.8%	Yes
Study Indicator 2b: Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter who were dispensed bronchodilator within 30 days of the event				
Baseline Period 1/1/08–12/31/08	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Remeasurement 3 1/1/11–12/31/11**	**Sustained Improvement¥**
46.6%	88.9%*	85.3%	76.5%	Yes
Study Indicator 3: Percentage of all-cause inpatient hospital discharges with an inpatient hospital readmission within 30 days of discharge date for COPD members^				
Baseline Period 1/1/08–12/31/08	**Remeasurement 1 1/1/09–12/31/09**	**Remeasurement 2 1/1/10–12/31/10**	**Remeasurement 3 1/1/11–12/31/11**	**Sustained Improvement¥**
28.0%	36.3%**	23.0%*	26.2%	‡

^A lower percentage indicates better performance.

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

**A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Table C.83—Quality Improvement Project Domain(s) of Care and Interventions
San Francisco Health Plan—San Francisco County
July 1, 2012, through June 30, 2013

QIP #1—Improving the Patient Experience		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Initial training and coaching sessions with clinics ◆ Developed communication training ◆ Continuing biweekly coaching sessions ◆ Monthly teleconferences with clinics ◆ Sponsored the San Francisco Quality Culture Series ◆ Rapid dramatic performance improvement ◆ Collaborated with Chinese Community Health Care Association and Experia Health
QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Pay-for-Performance incentives ◆ Practice Improvement Program combines incentives and technical assistance ◆ Training for clinic care managers through Center for Excellence in Primary Care

Table C.84—Quality Improvement Project Validation Activity
San Francisco Health Plan—San Francisco County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	90%	100%	*Met*
Internal QIPs				
Improving the Patient Experience	Annual Submission	87%	89%	*Partially Met*
	Annual Resubmission 1	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.85—Quality Improvement Project Average Rates*
San Francisco Health Plan—San Francisco County
(Number = 3 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	90%	0%	10%
Design Total		**98%**	**0%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	70%	20%	10%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**79%**	**14%**	**7%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

Table C.86—Quality Improvement Project Domain(s) of Care and Interventions
Santa Clara Family Health Plan—Santa Clara County
July 1, 2012, through June 30, 2013

QIP #1—Childhood Obesity Partnership and Education		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Member education: *5 Keys to Raising Healthy, Happy Eaters* and Packard Pediatric Weight Management Program ◆ Specialized family lifestyle management center: Pediatric Healthy Lifestyle Center ◆ Provider outreach ◆ Member outreach
QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Member outreach programs through clinical social workers ◆ Provide hospitals with discharge plan training sessions to ensure SCFHP members are provided a completed, plan-compliant discharge plan ◆ Provide members with tote bag that contains discharge plan

Table C.87—Quality Improvement Project Validation Activity
Santa Clara Family Health Plan—Santa Clara County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	80%	100%	*Met*
Internal QIPs				
Childhood Obesity Partnership and Education	Annual Submission	37%	38%	*Not Met*
	Annual Resubmission 1	88%	86%	*Partially Met*
	Annual Resubmission 2	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.88—Quality Improvement Project Average Rates*
Santa Clara Family Health Plan—Santa Clara County
(Number = 4 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	82%	18%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	61%	22%	17%
Design Total		**80%**	**13%**	**7%**
Implementation	VII: Sufficient Data Analysis and Interpretation	67%	25%	8%
	VIII: Appropriate Improvement Strategies	50%	50%	0%
Implementation Total		**61%**	**33%**	**6%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**Table C.89—Quality Improvement Project Domain(s) of Care and Interventions
Senior Care Action Network Health Plan—Los Angeles/Riverside/San Bernardino Counties
July 1, 2012, through June 30, 2013**

QIP #1—Care for Older Adults		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Member outreach programs ◆ Member education ◆ Member health risk assessment questionnaire ◆ Provide practitioners with standardized screening tools ◆ Develop on-line continuing medical education program for Care for Older Adults ◆ Develop clinical practice guidelines
QIP #2—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Pre-discharge coaching with member and family ◆ Review care escalation options ◆ Assist in scheduling usual physician appointment post discharge within seven business days ◆ Provide educational materials ◆ Coach educates member on various follow-up activities (e.g., bagging medications, medication review, call physician) ◆ Coach discusses long-term care options

Table C.90—Quality Improvement Project Validation Activity
Senior Care Action Network Health Plan—Los Angeles/Riverside/San Bernardino Counties
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
All-Cause Readmissions	Study Design Submission	80%	100%	*Met*
Internal QIPs				
Care for Older Adults	Annual Submission	83%	90%	*Partially Met*
	Annual Resubmission 1	91%	80%	*Not Met*
	Annual Resubmission 2	97%	90%	*Partially Met*
	Annual Resubmission 3	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Table C.91—Quality Improvement Project Average Rates*
Senior Care Action Network Health Plan—Los Angeles/Riverside/San Bernardino Counties
(Number = 5 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	88%	4%	8%
	VI: Accurate/Complete Data Collection**	93%	4%	4%
Design Total		**94%**	**2%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	83%	14%	3%
	VIII: Appropriate Improvement Strategies	94%	6%	0%
Implementation Total**		**87%**	**12%**	**2%**
Outcomes	IX: Real Improvement Achieved	100%	0%	0%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**100%**	**0%**	**0%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

Table C.92—Quality Improvement Project Outcomes
Senior Care Action Network Health Plan—Los Angeles/Riverside/San Bernardino Counties
July 1, 2012, through June 30, 2013

QIP #1—Care for Older Adults			
Study Indicator: Percentage of eligible members 66 years of age or older with at least one functional status assessment			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
54.9%	63.0%*	‡	‡
Study Indicator: Percentage of eligible members 66 years of age or older with at least one pain screening or pain management plan			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
26.2%	40.4%*	‡	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Appendix D. Individual Full-Scope Managed Care Plan Member Satisfaction Survey Results

The following key applies to the member satisfaction survey result tables below.

Table D.1—Star Ratings Crosswalk Used for CAHPS Measures

Star Rating	Adult and Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or above the 75th and below the 90th percentile
★★★ Good	At or above the 50th and below the 75th percentile
★★ Fair	At or above the 25th and below the 50th percentile
★ Poor	Below the 25th percentile

The symbol (+) indicates that the Medi-Cal managed care plan (MCP) had fewer than 100 respondents for a measure; therefore, caution should be exercised when evaluating these results.

Table D.2—Medi-Cal Managed Care County-Level Global Ratings
Alameda Alliance for Health—Alameda County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★★	★★★
Child	★★	★★	★★★★	★★★+

Table D.3—Medi-Cal Managed Care County-Level Composite Measures
Alameda Alliance for Health—Alameda County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★	★
Child	★	★	★★	★

Table D.4—Medi-Cal Managed Care Adult County-Level Global Ratings
Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, San Francisco, and Tulare Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Alameda	★+	★+	★+	★+
Contra Costa	★+	★+	★★+	★+
Fresno	★+	★+	★+	★+
Kings	★+	★★★+	★★★★+	★+
Madera	★★+	★+	★★★★★+	★+
Sacramento	★+	★+	★+	★★+
Santa Clara	★+	★★★★+	★+	★★+
San Francisco	★+	★+	★★+	★+
Tulare	★	★★+	★★+	★★+

**Table D.5—Medi-Cal Managed Care Child County-Level Global Ratings
Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, San Francisco, and Tulare Counties**

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Alameda	★★+	★★+	★★★★★+	★★★+
Contra Costa	★★★	★★★+	★★★+	★★★★★+
Fresno	★★	★+	★★★+	★+
Kings	★+	★+	★+	★★★★+
Madera	★★★★	★★+	★★+	★★★★★+
Sacramento	★	★+	★+	★+
Santa Clara	★	★+	★	★★★★★+
San Francisco	★+	★★★★★+	★★★★+	★★★★★+
Tulare	★★★	★+	★★+	★★★★★+

**Table D.6—Medi-Cal Managed Care Adult County-Level Composite Measures
Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, San Francisco, and Tulare Counties**

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Alameda	★+	★+	★+	★+
Contra Costa	★★+	★+	★★★+	★+
Fresno	★+	★★+	★+	★+
Kings	★★+	★★★★+	★★★★★+	★★+
Madera	★★+	★+	★★★★★+	★★★★+
Sacramento	★+	★+	★+	★+
Santa Clara	★★+	★+	★★★+	★+
San Francisco	★+	★+	★★★+	★+
Tulare	★+	★+	★★+	★+

Table D.7—Medi-Cal Managed Care Child County-Level Composite Measures Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, San Francisco, and Tulare Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Alameda	★+	★+	★+	★★★+
Contra Costa	★★★★+	★★★+	★★★+	★★★★★+
Fresno	★★+	★★+	★+	★★★+
Kings	★+	★+	★+	★+
Madera	★★+	★+	★+	★+
Sacramento	★+	★+	★+	★+
Santa Clara	★+	★+	★+	★+
San Francisco	★★+	★+	★★+	★+
Tulare	★+	★+	★+	★★★★★+

Table D.8—Medi-Cal Managed Care County-Level Global Ratings CalOptima—Orange County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★★★	★★	★★★★	★★★
Child	★★★	★★	★★★★	★

Table D.9—Medi-Cal Managed Care County-Level Composite Measures CalOptima—Orange County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★★★	★★	★★	★★★★★
Child	★	★	★	★

Table D.10—Medi-Cal Managed Care Adult County-Level Global Ratings
CalViva Health—Fresno, Kings, and Madera Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Fresno	★	★	★	★+
Kings	★★	★★★+	★★★★★+	★★★★★+
Madera	★	★+	★+	★★★+

Table D.11—Medi-Cal Managed Care Child County-Level Global Ratings
CalViva Health—Fresno, Kings, and Madera Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Fresno	★★	★	★	★★★★★+
Kings	★★	★+	★★★★★+	★+
Madera	★★★★	★★★+	★★★	★★★★★+

Table D.12—Medi-Cal Managed Care Adult County-Level Composite Measures
CalViva Health—Fresno, Kings, and Madera Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Fresno	★	★	★	★★+
Kings	★★+	★★+	★+	★+
Madera	★+	★+	★+	★★+

Table D.13—Medi-Cal Managed Care Child County-Level Composite Measures
CalViva Health—Fresno, Kings, and Madera Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Fresno	★★	★	★	★★
Kings	★+	★+	★★+	★★★★★+
Madera	★★★+	★+	★+	★★★★+

Table D.14—Medi-Cal Managed Care County-Level Global Ratings
Care1st Partner Plan—San Diego County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★	★
Child	★★	★	★★★	★★★★★+

Table D.15—Medi-Cal Managed Care County-Level Composite Measures
Care1st Partner Plan—San Diego County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★★	★★★
Child	★	★	★	★★★

Table D.16—Medi-Cal Managed Care Adult County-Level Global Ratings
CenCal Health—San Luis Obispo and Santa Barbara Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
San Luis Obispo	★	★★★★	★★★	★★★+
Santa Barbara	★★	★★	★★★★	★★★★

Table D.17—Medi-Cal Managed Care Child County-Level Global Ratings
CenCal Health—San Luis Obispo and Santa Barbara Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
San Luis Obispo	★	★	★	★+
Santa Barbara	★★★	★★★	★★★★	★★★★★+

Table D.18—Medi-Cal Managed Care Adult County-Level Composite Measures
CenCal Health—San Luis Obispo and Santa Barbara Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
San Luis Obispo	★★★★	★★★★★	★★	★★★★+
Santa Barbara	★★★	★★★	★★★★	★★★+

Table D.19—Medi-Cal Managed Care Child County-Level Composite Measures
CenCal Health—San Luis Obispo and Santa Barbara Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
San Luis Obispo	★+	★+	★	★+
Santa Barbara	★★	★	★	★★★★

Table D.20—Medi-Cal Managed Care Adult County-Level Global Ratings
Central California Alliance for Health—Merced and Monterey/Santa Cruz Counties

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Merced	★	★	★★★★	★★+
Monterey/Santa Cruz	★★★	★★★★★	★★★★★	★★★★★

Table D.21—Medi-Cal Managed Care Child County-Level Global Ratings
Central California Alliance for Health—Merced and Monterey/Santa Cruz Counties

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Merced	★	★	★	★★★★★+
Monterey/Santa Cruz	★★★	★	★★★★	★★★★★+

Table D.22—Medi-Cal Managed Care Adult County-Level Composite Measures
Central California Alliance for Health—Merced and Monterey/Santa Cruz Counties

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Merced	★★	★	★★	★★★★+
Monterey/Santa Cruz	★★★★	★★★	★★★★★	★★★★★+

Table D.23—Medi-Cal Managed Care Child County-Level Composite Measures
Central California Alliance for Health—Merced and Monterey/Santa Cruz Counties

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Merced	★+	★+	★+	★★+
Monterey/Santa Cruz	★★	★	★	★

Table D.24—Medi-Cal Managed Care County-Level Global Ratings
Community Health Group Partnership Plan—San Diego County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★★★	★★
Child	★★★	★★	★★★★★	★★★★★

Table D.25—Medi-Cal Managed Care County-Level Composite Measures
Community Health Group Partnership Plan—San Diego County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★	★★
Child	★	★	★	★★★★

Table D.26—Medi-Cal Managed Care County-Level Global Ratings
Contra Costa Health Plan—Contra Costa County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★★★	★★
Child	★	★	★★★	★[+]

Table D.27—Medi-Cal Managed Care County-Level Composite Measures
Contra Costa Health Plan—Contra Costa County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★★	★★★★
Child	★	★	★	★★

Table D.28—Medi-Cal Managed Care County-Level Global Ratings
Gold Coast Health Plan—Ventura County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★★	★★★	★★★★★	★★★★★
Child	★	★	★★★	★★

Table D.29—Medi-Cal Managed Care County-Level Composite Measures
Gold Coast Health Plan—Ventura County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★★★	★	★★★	★★★
Child	★	★	★	★

**Table D.30—Medi-Cal Managed Care Adult County-Level Global Ratings
Health Net Community Solutions, Inc.—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties**

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Kern	★+	★+	★+	★★★★★+
Los Angeles	★	★	★	★+
Sacramento	★+	★+	★+	★★+
San Diego	★+	★+	★+	★★+
Stanislaus	★+	★+	★★+	★★★★★+
Tulare	★★★+	★★+	★★★+	★+

**Table D.31—Medi-Cal Managed Care Child County-Level Global Ratings
Health Net Community Solutions, Inc.—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties**

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Kern	★+	★+	★★+	★★★★+
Los Angeles	★★★	★	★★	★★★★★+
Sacramento	★+	★+	★+	★★+
San Diego	★+	★+	★+	★★★★★+
Stanislaus	★+	★+	★+	★★★★★+
Tulare	★★★★★	★★+	★★★★+	★★★★★+

**Table D.32—Medi-Cal Managed Care Adult County-Level Composite Measures
Health Net Community Solutions, Inc.—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties**

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Kern	★+	★+	★+	★★★★+
Los Angeles	★	★	★	★+
Sacramento	★+	★+	★+	★+
San Diego	★+	★+	★+	★+
Stanislaus	★+	★+	★+	★+
Tulare	★+	★+	★+	★+

Table D.33—Medi-Cal Managed Care Child County-Level Composite Measures Health Net Community Solutions, Inc.—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Kern	★+	★+	★+	★+
Los Angeles	★	★	★	★★★★
Sacramento	★+	★+	★+	★+
San Diego	★+	★+	★+	★★+
Stanislaus	★★★★+	★★★★+	★+	★★★★★+
Tulare	★★★★+	★+	★+	★★+

Table D.34—Medi-Cal Managed Care County-Level Global Ratings Health Plan of San Joaquin—San Joaquin County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★★	★	★	★★★★
Child	★★★	★	★	★★★★+

Table D.35—Medi-Cal Managed Care County-Level Composite Measures Health Plan of San Joaquin—San Joaquin County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★★	★	★	★★★★+
Child	★	★	★	★★★

Table D.36—Medi-Cal Managed Care County-Level Global Ratings Health Plan of San Mateo—San Mateo County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★★★	★★★★	★★★★	★★★★★
Child	★★★	★★★	★★★★★	★★★★★

**Table D.37—Medi-Cal Managed Care County-Level Composite Measures
Health Plan of San Mateo—San Mateo County**

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★★	★	★★	★★★
Child	★	★	★	★★★

**Table D.38—Medi-Cal Managed Care County-Level Global Ratings
Inland Empire Health Plan—San Bernardino/Riverside County**

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★★★	★	★	★★★
Child	★★★	★	★	★★★+

**Table D.39—Medi-Cal Managed Care County-Level Composite Measures
Inland Empire Health Plan—San Bernardino/Riverside County**

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★★	★	★	★★★★
Child	★	★	★	★★★★

**Table D.40—Medi-Cal Managed Care County-Level Global Ratings
Kaiser–Sacramento County**

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★★★★★	★★★★★	★★★★	★★★★★
Child	★★★★★	★★★★★	★★★★★	★★★★★+

**Table D.41—Medi-Cal Managed Care County-Level Composite Measures
Kaiser–Sacramento County**

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★★★★★	★★★★★	★★★★	★★★★★
Child	★★★★★	★★★★★	★★★★★	★★★★★

Table D.42—Medi-Cal Managed Care County-Level Global Ratings Kaiser–San Diego County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★★★★★	★★★★★	★★★★★	★★★★★
Child	★★★★★	★★★★★	★★★★★	★★★★★

Table D.43—Medi-Cal Managed Care County-Level Composite Measures Kaiser–San Diego County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★★★★★	★★★★★	★★★★★	★★★★★
Child	★★★★	★★★★	★★★★	★★★★★

Table D.44—Medi-Cal Managed Care County-Level Global Ratings Kern Family Health Care—Kern County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★	★
Child	★★	★	★	★★+

Table D.45—Medi-Cal Managed Care County-Level Composite Measures Kern Family Health Care—Kern County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★	★★★
Child	★	★	★	★★★

Table D.46—Medi-Cal Managed Care County-Level Global Ratings L.A. Care Health Plan—Los Angeles County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★	★
Child	★★★	★	★★	★★★★+

Table D.47—Medi-Cal Managed Care County-Level Composite Measures
L.A. Care Health Plan—Los Angeles County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★	★★
Child	★	★	★	★★★

Table D.48—Medi-Cal Managed Care Adult County-Level Global Ratings
Molina Healthcare of California Partner Plan, Inc.—Sacramento, San Bernardino/Riverside, and San Diego Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Sacramento	★+	★+	★+	★★★+
Riverside/San Bernardino	★	★+	★+	★+
San Diego	★	★+	★★★+	★+

Table D.49—Medi-Cal Managed Care Child County-Level Global Ratings
Molina Healthcare of California Partner Plan, Inc.—Sacramento, San Bernardino/Riverside, and San Diego Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Sacramento	★+	★+	★+	★+
Riverside/San Bernardino	★	★	★	★★★★★+
San Diego	★★	★	★★★	★★★★★+

Table D.50—Medi-Cal Managed Care Adult County-Level Composite Measures
Molina Healthcare of California Partner Plan, Inc.—Sacramento, San Bernardino/Riverside, and San Diego Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Sacramento	★+	★+	★+	★★+
Riverside/San Bernardino	★+	★+	★+	★★★★+
San Diego	★+	★+	★★+	★+

Table D.51—Medi-Cal Managed Care Child County-Level Composite Measures Molina Healthcare of California Partner Plan, Inc.—Sacramento, San Bernardino/Riverside, and San Diego Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Sacramento	★+	★+	★+	★★+
Riverside/San Bernardino	★+	★+	★	★★★+
San Diego	★	★	★	★★★★★+

Table D.52—Medi-Cal Managed Care Adult County-Level Global Ratings Partnership HealthPlan of California—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Marin	★★★+	★★★★+	★★★★+	★★★★★+
Mendocino	★+	★★★+	★★★★★+	★★★★★+
Napa/Solano/Yolo	★★	★★	★★★★★	★★★★★+
Sonoma	★★	★★★+	★★★★★+	★★★★+

Table D.53—Medi-Cal Managed Care Child County-Level Global Ratings Partnership HealthPlan of California—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Marin	★★+	★+	★★+	★★+
Mendocino	★+	★+	★★+	★+
Napa/Solano/Yolo	★★	★★★	★★★★★	★★★★+
Sonoma	★	★	★★★★★	★★★★+

Table D.54—Medi-Cal Managed Care Adult County-Level Composite Measures Partnership HealthPlan of California—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Marin	★★★+	★★+	★★+	★★+
Mendocino	★★+	★★★★+	★★★★+	★★★★+
Napa/Solano/Yolo	★★★	★	★★★★	★★★★+
Sonoma	★★★★★+	★★★★★+	★★★+	★+

Table D.55—Medi-Cal Managed Care Child County-Level Composite Measures Partnership HealthPlan of California—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Marin	★+	★★+	★+	★★★+
Mendocino	★★★+	★★+	★+	★★★★★+
Napa/Solano/Yolo	★★★	★	★	★★★★★+
Sonoma	★+	★★★+	★+	★+

Table D.56—Medi-Cal Managed Care County-Level Global Ratings San Francisco Health Plan—San Francisco County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★★★	★★★	★★★
Child	★★	★	★★★	★+

Table D.57—Medi-Cal Managed Care County-Level Composite Measures San Francisco Health Plan—San Francisco County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★★	★
Child	★	★	★	★★

Table D.58—Medi-Cal Managed Care County-Level Global Ratings
Santa Clara Family Health Plan—Santa Clara County

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★★	★	★★	★★★
Child	★★★	★	★★★	★★★★

Table D.59—Medi-Cal Managed Care County-Level Composite Measures
Santa Clara Family Health Plan—Santa Clara County

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult	★	★	★	★
Child	★	★	★	★★

Appendix E. Grid of 2011–12 EQR Recommendations and Medi-Cal Managed Care's Follow-Up

The table below provides the 2011–12 external quality review recommendations and the Department of Health Care Services Medi-Cal Managed Care program's (MCMC's) actions taken through June 30, 2013, that address the recommendations.

2011–12 External Quality Review Recommendation	MCMC Actions through June 30, 2013, that Address the Recommendation
MCMC should ensure that a comprehensive audit is conducted at least once within a three-year period with all managed care plans (MCPs) and that all federal requirements are met.	In 2012, MCMC established the Plan Monitoring Unit (PMU) within the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD). PMU is responsible for monitoring all managed care health plans which includes, but is not limited to: 1. Assuming the lead role in recommending modifications to the DHCS Audit & Investigations (A&I) Division audit tool. 2. Ensuring that all managed care health plans are audited within required time frames. 3. Participating in audit entrance and exit conferences to ensure a comprehensive audit has been completed. 4. Acting as the central repository for all managed care audits competed by A&I. 5. Enforcing corrective action plans (CAPs) for all managed care audits that contain finding(s). DHCS and the Department of Managed Health Care (DMHC) have established a biweekly audit conference call to discuss the status of audits being performed and the CAPs, and to collaborate on the ongoing development of a coordinated audit schedule. DHCS is on track to institute a policy of auditing all managed care health plans annually beginning in 2015. Once A&I completes the audit and conducts an exit conference with the managed care health plan, the audit results are sent to PMU for review. A formal, written procedure has been established for requiring managed care health plans to submit a CAP if an audit contains any findings. PMU has also established a formal audit tracking and audit CAP tracking process that is presented to MMCD management weekly. MMCD and A&I have established a formal process for requesting modifications to the audit tool. PMU is responsible for monitoring State and federal regulatory changes to ensure that the audit tool is modified as deemed necessary.