Medi-Cal Managed Care Technical Report

July 1, 2013–June 30, 2014

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

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Commonly Used Abbreviations and Acronyms

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

- **A&I**—Audits and Investigations Division
- **ADHD**—attention deficit hyperactivity disorder
- **AHRQ**—Agency for Healthcare Research and Quality
- **CAHPS®**—Consumer Assessment of Healthcare Providers and Systems[1]
- **CANS**—Child and Adolescent Needs and Strengths
- **CAP**—corrective action plan
- **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
- **IQIP**—internal quality improvement project
- **IS**—information systems
- **ITSD**—Information Technology Services Division
- **LI**—Local Initiative
- **LTC**—long-term care

[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).

- **MCMC**—Medi-Cal Managed Care program
- **MCP**—Medi-Cal managed care health plan
- **MMCD**—Medi-Cal Managed Care Division
- **MPL**—minimum performance level
- **NCQA**—National Committee for Quality Assurance
- **Non-SPD**—Non-Seniors and Persons with Disabilities
- **PCP**—primary care provider
- **PDSA**—Plan-Do-Study-Act
- **QIP**—quality improvement project
- **SPD**—Seniors and Persons with Disabilities
- **TPM**—Two-Plan Model
- **W&I**—Welfare and Institutions Code

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 health 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, and each quality improvement project (QIP).

As in previous years, 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 meet 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. Additionally, take into account limited resources when determining which strategies to implement.
- 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 QIPs, when appropriate.

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

- Report outcomes achieved through strategies outlined in the *Medi-Cal Managed Care Program Quality Strategy Report,* and indicate whether strategies will be expanded, modified, or eliminated to achieve improvement in key focus areas.
- Explore with the EQRO a redesigned QIP process that supports the MCPs in conducting QIPs using rapid-cycle techniques and a validation process that facilitates greater technical assistance to the MCPs and feedback throughout the rapid-cycle QIP process.

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. DHCS's documentation of actions taken in response to HSAG's 2012–13 external quality review (EQR) recommendations are included in Appendix D.

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, 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—Encounter Data Validation

Section 7 describes an optional activity and the status of the activity at the time this report was produced.

Section 8—Overall Findings, Conclusions, and Recommendations Related to External Quality Review Activities summarizes MCPs' performance for each of the review activities.

Section 9—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 Health Plan Performance Measure Results

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

Appendix C—Individual Managed Care Health Plan Quality Improvement Project Information

Appendix D—Grid of 2012–13 EQR Recommendations and Medi-Cal Managed Care's Follow-Up provides the 2012–13 EQR recommendations and MCMC's actions that address the recommendations.

Purpose of Report

DHCS administers California's Medicaid program (Medi-Cal) through its fee-for-service (FFS) and managed care delivery systems. DHCS's Medi-Cal Managed Care Division (MMCD)[3] oversees the MCMC, which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)[4] through a combination of contracted full-scope and specialty 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.

42 CFR §438.364[5] requires that states use an 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 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 QIP. While not required, the State can elect to include optional EQR activities, such as encounter data validation results.

This report provides:

- A description of MCMC.
- A description of MCMC's quality strategy and quality improvement objectives.
- A description of the scope of EQR activities for the period of July 1, 2013, through June 30, 2014, 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 and QIPs. The report

[3] MMCD was reorganized into two divisions as of December 2014—Managed Care Operations Division and Managed Care Quality and Monitoring Division. Since the reorganization occurred outside the review dates for this report, MMCD is used for this report.

[4] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: February 11, 2015.

[5] 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.

also assesses encounter data validation, an optional EQR monitoring activity that helps 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, 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 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 23 full-scope MCPs and three specialty MCPs to provide health care services in all 58 counties throughout California for approximately 7.7 million beneficiaries.[6] DHCS operates MCMC through a service delivery system that encompasses six models of managed care for its full-scope services, the: Two-Plan Model (TPM)—both local initiative (LI) and commercial plan (CP), Geographic Managed Care (GMC) model, County Organized Health System (COHS) model, Regional Model (RM), Imperial model, and San Benito model. DHCS monitors MCP performance across model types. Following is a description of each model type. Table 2.1 shows participating MCPs by model type.

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. A COHS has been implemented in 22 counties.

[6] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: February 11, 2015.

Geographic Managed Care

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

Imperial

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

Regional Model

In RM counties, DHCS contracts with two CPs to provide MCMC services in 39 counties.

San Benito

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

Two-Plan

In TPM counties, MCMC beneficiaries may choose between two MCPs; one MCP is an LI and the other a CP. DHCS contracts with both plans. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. The TPM has been implemented in 14 counties.

Specialty Managed Care Health Plans

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

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

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

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

Medi-Cal Expansion

As part of the expansion authority under Section 1115 of the Social Security Act,[7] MCMC expanded into 28 rural counties of California effective November 1, 2013. Anthem Blue Cross Partnership Plan and California Health & Wellness contracted with DHCS to provide MCMC services for 18 rural counties—Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba. Anthem Blue Cross Partnership Plan also expanded into San Benito County to provide MCMC services, and California Health & Wellness contracted with DHCS to provided MCMC services in Imperial County. Also as part of the expansion authority, Kaiser North contracted with DHCS to provide MCMC services in Amador, El Dorado, and Placer counties beginning November 1, 2013; Molina Healthcare of California Partner Plan, Inc., contracted with DHCS to provide MCMC services in Imperial County beginning September 1, 2013; and Partnership HealthPlan of California contracted with DHCS to provided MCMC services in Del-Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties beginning September 1, 2013.

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.

[7] Medicaid.gov, Section 1115 Demonstrations. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html. Accessed on: February 12, 2015.

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.[8]

Access

In the preamble to the CFR,[9] 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."[10] 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."[11] Timeliness includes the interval between identifying a need for specific tests and treatments and actually receiving those services.[12]

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

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[8] 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. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 19, 2013.

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

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

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

[12] Ibid.

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 (Statewide Collaborative QIP Measure)	√		√
Ambulatory Care—Emergency Department (ED) Visits‡	**	**	**
Ambulatory Care—Outpatient Visits‡	**	**	**
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors and ARBs	√		
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 to 24 Months			√
Children and Adolescents' Access to Primary Care Practitioner—25 Months to 6 Years			√
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years			√
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years			√
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	√	√	√

Performance Measures	Quality	Timeliness	Access
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	√	√	√
School Attendance	√		
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(s) of care.		

‡This is a utilization measure, which measures the volume of services used.

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

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

Medi-Cal Managed Care Quality Strategy

42 CFR §438.200 and §438.202 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 October 2014, to comply with federal regulations, DHCS's MMCD issued an annual assessment of the *Medi-Cal Managed Care Program Quality Strategy Report*,[13] which reflects DHCS's renewed emphasis on quality and outcomes. The annual assessment report outlines efforts designed to achieve the three linked goals that are the foundation of DHCS's quality strategy:[14]

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

The DHCS goals are linked to the National Quality Strategy's three overarching aims:[15]

1. Better Care: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
2. Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health, in addition to delivering higher-quality care.
3. Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.

The *Medi-Cal Managed Care Program Quality Strategy Report* includes a description of the program background and structure, contractual standards, and oversight and monitoring activities. Additionally, the report outlines the operational processes implemented by MCMC to assess the

[13] The *Medi-Cal Managed Care Program Baseline Quality Report—April 2012*; *Medi-Cal Managed Care Program Quality Strategy Report—Annual Update, June 2013*; and *Medi-Cal Managed Care Program Quality Strategy Report—Annual Assessment, October 2014* are available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx#qualitystrategyreports. Accessed on: March 26, 2015.

[14] California Department of Health Care Services. DHCS Strategy for Quality Improvement in Health Care. Available at: http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2013.pdf. Accessed on: February 11, 2015.

[15] National Quality Strategy. Available at: http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.pdf. Accessed on: February 11, 2015.

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.

Note: Although the October 2014 annual assessment of the *Medi-Cal Managed Care Program Quality Strategy Report* was released outside the review dates for this report, HSAG includes information from the report at the request of DHCS and because the information was available at the time this report was produced.

Annual Assessment Overview

The October 2014 annual assessment report provides information on MCMC's evaluation of the MCPs' performance, lists measurable objectives for key indicators, includes interventions to improve performance, describes changes in service delivery and contractual standards, and outlines enhancements in DHCS's oversight and monitoring of MCMC.

The framework for the annual assessment report is based on the seven priorities of the DHCS quality strategy, as well as three commitments from the *California Department of Health Care Services Strategic Plan 2013–2017*.[16] The seven priorities listed in the DHCS quality strategy are:[17]

- Deliver effective, efficient, and affordable care.
- Engage persons and families in their health.
- Enhance communication and coordination of care.
- Foster healthy communities.
- Eliminate health disparities.
- Advance prevention.
- Improve patient safety.

The three commitments from the DHCS strategic plan are:

- Treat the whole person by coordinating and integrating medical, dental, mental health, substance use treatment, and LTC services.
- Hold ourselves and our providers, health plans, and partners accountable for performance.

[16] California Department of Health Care Services. Strategic Plan 2013–2017. Available at: http://www.dhcs.ca.gov/Documents/DHCSStrategicPlan.pdf. Accessed on: February 11, 2015.

[17] California Department of Health Care Services. DHCS Strategy for Quality Improvement in Health Care. Available at: http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2013.pdf. Accessed on: February 11, 2015.

- Maintain effective, open communication and engagement with the public, our partners, and other stakeholders.

The annual assessment focused on performance in three areas critical for the health of Medi-Cal MCP members:

- Maternal and child health: timely postpartum care and immunizations of 2-year-olds
- Chronic disease management: hypertension control and diabetes care
- Prevention: tobacco cessation

In the October annual assessment report, MCMC includes the following objectives for services to be provided in 2015:

- Increase the Medi-Cal weighted average for timely postpartum care to at least 62 percent for measurement year 2015.
- Increase the percentage of MCMC counties meeting the minimum performance level for timely postpartum care to at least 80 percent for measurement year 2015.
- Increase the proportion of African-American postpartum women with timely postpartum care to at least 38 percent for measurement year 2015.
- Increase to at least 80 percent the proportion of MCP members with up-to-date immunizations by their second birthday during measurement year 2015 (to be reported in 2016).
- Increase to 61 percent the proportion of MCP members 18 to 85 years of age with hypertension whose blood pressure is adequately controlled during measurement year 2015 (to be reported in 2016).
- Decrease to 39 percent the proportion of MCP members with diabetes who had HbA1c >9.0 percent in measurement year 2015 (to be reported in 2016).
- Increase to 88 percent the proportion of MCP members with diabetes who have had HbA1c testing during measurement year 2015 (to be reported in 2016).
- Increase to 30 percent the proportion of health care providers participating in the Medi-Cal Electronic Health Records incentive program who report on the percentage of adults with diabetes who have HbA1c >9.0 percent.
- Increase to 76 percent the median proportion of smokers who report being counseled to quit in the prior six months (proposed to be measured during the 2016 CAHPS survey).
- Increase to 45 percent the median proportion of smokers who report a provider discussed tobacco cessation medications in the prior six months (proposed to be measured during the 2016 CAHPS survey).
- Improve patient safety (measureable target to be determined at a later date).

- Treat the whole person by coordinating and integrating medical, dental, mental health, substance use treatment services, and LTC (measureable target to be determined at a later date).
- Hold ourselves and our providers, health plans, and partners accountable for performance (measureable target to be determined at a later date).
- Maintain effective, open communication and engagement with the public, our partners, and other stakeholders (measureable target to be determined at a later date).

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.

Quality Strategy Goals

The MCMC 2013 quality strategy goals include the following:

- 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.
- 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 MCMC 2013 quality strategy objectives are listed below, along with information on the status of each objective as presented in the October 2014 annual assessment report:

- 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.

Status: Through its contracts with the Medi-Cal MCPs, DHCS requires that each Medi-Cal member is assigned to a primary care provider (PCP)/clinic and the PCP serves as the member's medical home. On November 1, 2013, DHCS completed the expansion of Medi-Cal MCPs to the 28 rural counties where Medi-Cal members did not previously have access to managed care. In spring 2014, DHCS began renewing its Affordable Care Act Section 2703 Health Homes efforts, as authorized under AB 361 (Chapter 642, Statutes of 2013), by convening internal work groups and beginning the stakeholder engagement process to initiate policy and program development. Additionally, DHCS entered into a three-way contract with CMS and the Cal MediConnect Medicare-Medicaid Plans under the Coordinated Care Initiative (CCI) April 1, 2014, that will continue through December 31, 2017. A fundamental goal of the CCI is increased care coordination, integrating physical health, behavioral health (which includes both mental health and substance use), and long-term services and supports into one care delivery model. Each Cal MediConnect Medicare-Medicaid Plan is required to have care coordination staff members who are accountable for providing care coordination services, which include assuring appropriate referrals and timely, two-way transmission of useful enrollee information, obtaining reliable and timely information about services other than those provided by the primary care provider, participating in the initial assessment, and supporting safe transitions in care for enrollees moving between settings. As part of that agreement, CMS and DHCS will be monitoring a variety of metrics reported by the contracted health plans to evaluate how effectively these goals are being met.

- Implement one or more performance standards and measures that would require MCPs to evaluate and improve SPD health outcomes by HEDIS reporting year 2013.

  Status: For services provided in calendar year (CY) 2012 and 2013, MCPs reported (in 2013 and 2014) five HEDIS performance measures (18 indicators total) for the SPD and non-SPD populations. Note: While not mentioned in the October 2014 annual assessment report, as part of the process for developing the MCP-specific evaluation reports, when SPD rates were worse than the non-SPD rates, the EQRO recommended that MCPs assess the factors for the worse SPD rates to ensure that the MCP is meeting the needs of the SPD population. In the following year's MCP-specific evaluation report process, the MCPs are required to provide information on actions taken to address the recommendations, and the EQRO assesses if the efforts were successful.

- 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.

  Status: COHS contract revisions were completed in September 2013 for Partnership HealthPlan of California and in November 2013 for the remaining COHS MCPs. All MCPs were included in the expansion of outpatient mental health and substance use disorder benefits starting in January 2014. This was reflected in contract amendments in December 2013. DHCS is currently working on a larger contract amendment to better align all contracts.

- Continue a statewide collaboration with MCPs through 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.

  Status: The status of these efforts is documented in the *Statewide Collaborative Quality Improvement Project All-Cause-Readmissions Baseline Report June 2013–May 2014*.[18]

- Administer the 2013 CAHPS survey to all plans, with results available in early 2014.

  Status: Results of the survey were analyzed by the EQRO and are included in the *Medi-Cal Managed Care 2013 CAHPS® Survey Summary Report*.[19] Note: The EQRO summarized results of the *Medi-Cal Managed Care 2013 CAHPS® Survey Summary Report* in its 2012–13 *Medi-Cal Managed Care Technical Report*; however, the CAHPS survey report had not yet been publically released at the time the October 2014 annual assessment report was produced. Since the CAHPS survey report was publically available when this *Medi-Cal Managed Care Technical Report* was produced, HSAG included the link to the CAHPS survey summary report.

- Establish a process by June 2013 for timely notification of MCPs to ensure 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.

  Status: On April 3, 2014, DHCS released All Plan Letter 13-013 (Revised), which established continuity of care requirements for beneficiaries transitioning to an MCP who had an MER denied for clinical reasons. DHCS provides all MCPs with a weekly data file that identifies the impacted beneficiaries, their provider, and the International Classification of Diseases (ICD)-9 code.

- 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 (AMQG).

  Status: In January 2014, DHCS submitted its AMQG annual report to CMS. As part of the annual report, DHCS reported on 16 of the Initial Core Set of Adult Health Care Quality measures, including pertinent data stratification and updates on the two QIPs: *Improving the Post-Partum Care Rate* and *Improving Diabetes Care among Medi-Cal Members*. In July 2014, DHCS submitted its second semiannual report to CMS which provided further updates on measure collection and analysis, as well as QIP updates. The MMCD has been an important partner in AMQG activities, including data analysis and participation in the two QIPs.

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[18] Health Services Advisory Group. *Statewide Collaborative Quality Improvement Project All-Cause Readmissions Baseline Report June 2013–May 2014*. California Department of Health Care Services, June 2014. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2013-14_QIP_Coll_ACR_Baseline_Report_F1.pdf. Accessed on: February 11, 2015.

[19] Health Services Advisory Group. *Medi-Cal Managed Care 2013 CAHPS® Survey Summary Report,* California Department of Health Care Services, April 2014. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/CAHPS_Reports/CA2012-13_CAHPS_Summary_Report_F3.pdf. Accessed on: February 11, 2015.

- Reduce the smoking rate among MCP members.

  Status: DHCS will monitor MCP smoking prevalence trends using data collected from tobacco questions in the CAHPS survey. DHCS developed an All Plan Letter detailing enhancements to tobacco use treatment in MCPs. The new policy requires MCPs to:

  - Assess each member's tobacco use through the Individual Health Education Behavioral Assessment and the Staying Healthy Assessment.
  - Cover all seven Food and Drug Administration-approved tobacco cessation medications for adults who smoke or use other tobacco products (at least one medication must be available without prior authorization).
  - Ensure that individual, group, and telephone counseling is offered to members who wish to quit smoking whether or not those members opt to use tobacco cessation medications.
  - Cover two independent quit attempts per year with no minimum break in between.
  - Provide services to pregnant women consistent with Affordable Care Act requirements and require MCPs to inform and educate clinicians regarding effective tobacco use treatment strategies consistent with the U.S. Department of Health and Human Services, Public Health Services *Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update*.

- Continue to consistently review the process to engage stakeholders and advocates in policy development.

  Status: DHCS indicated that this is an ongoing activity and meets with its managed care advisory group quarterly, at a minimum. Also, DHCS frequently sends documents to stakeholders for review and convenes one-time work groups.

Compliance Standards

42 CFR §438.358 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 MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities. This report section describes and assesses those review and monitoring activities.

Conducting the Review

The *Medi-Cal Managed Care Program Quality Strategy Report,*[20] *October 2014*, is DHCS's most recently published 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.

For this reporting period, DHCS used multiple review activities, including DHCS readiness reviews, DHCS medical performance audits, DHCS monitoring reviews, Department of Managed Health Care (DMHC) Knox-Keene medical surveys, and DMHC 1115 Medicaid Waiver Seniors and Persons with Disabilities enrollment surveys (referred to in this report as "SPD medical surveys"). While some areas of these reviews are similar, the results are separate and distinct.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

[20] California Department of Health Care Services. *Medi-Cal Managed Care Program Quality Strategy—Annual Assessment, October 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx#qualitystrategyreports. Accessed on: February 12, 2015.

Medical Audits and SPD Medical Surveys

Historically, DHCS and DMHC collaborated to conduct medical audits and surveys of many of the Medi-Cal MCPs. These medical audits/surveys were conducted for each Medi-Cal MCP approximately once every three years to assess MCPs' compliance with contract requirements and State and federal regulations.

As part of the 1115 Waiver, DHCS received authorization from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-COHS counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During the review period for this report (July 1, 2013, through June 30, 2014), DHCS began a transition of medical monitoring processes to enhance oversight of MCPs by (1) increasing DHCS's Audits & Investigation Division (A&I) medical performance audit frequency from once every three years to once each year; and (2) augmenting the monitoring protocols with DMHC's 1115 Waiver SPD medical surveys, which are conducted once every three years. Furthermore, under DHCS's new monitoring protocols, any deficiencies identified in either DHCS's A&I medical performance audits or DMHC's 1115 Waiver SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

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, HSAG assessed whether MCMC continued to ensure 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.

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

During the review period for this report, 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 1115 Medicaid Waiver SPD medical surveys.
- DMHC routine Knox-Keene medical surveys.
- DHCS A&I medical performance audits.
- DHCS member rights and program integrity monitoring reviews.

Below are the four types of reviews conducted and the areas assessed within each type of review. While DHCS restructured its monitoring processes during the 2013–14 review period, results from all four types of reviews were reported during this review period.

DMHC 1115 Medicaid Waiver SPD Medical Surveys

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

DMHC Routine Knox-Keene 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 Medical Performance 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
- 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

Assessment of MCP Monitoring

During the previous reporting period (July 1, 2012, through June 30, 2013), HSAG evaluated MCMC's compliance monitoring process of the MCPs against federal requirements. HSAG had six recommendations for the MCPs and three recommendations for MCMC. A summary of the actions taken by MCMC related to each recommendation is provided in Appendix D.

Compliance Results

MCMC Follow-up on 2012–13 Monitoring Results

As indicated above, during the 2013–14 reporting period, MCMC transitioned to new monitoring protocols to ensure the MCPs' progress with addressing deficiencies is actively and continuously monitored until full resolution is achieved.

In the 2012–13 MCP-specific evaluation reports, HSAG reported on outstanding findings. In its assessment of the compliance reports submitted by DHCS to HSAG for the 2013–14 reporting period, HSAG found the following:

- Two MCPs were required to submit a CAP—one for results from a DHCS A&I medical performance audit and the other for results from a DMHC routine Knox-Keene medical survey. DHCS reported the MCPs fully resolved the CAPs during the 2013–14 reporting period. Additionally, one of the MCPs fully resolved deficiencies identified through its DMHC 1115 Medicaid Waiver SPD medical survey.
- DHCS indicated that one MCP fully resolved one deficiency and made progress on resolving two deficiencies identified through its SPD medical survey. The same MCP's self-report indicated that it resolved the one outstanding finding from its most recent routine medical survey.[21]
- One MCP's self-report indicated full resolution of one outstanding finding from its MR/PIU review.
- One MCP's self-report indicated full resolution of two deficiencies identified through its SPD medical survey.

Monitoring Results for 2013–14

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, 2013). As indicated above, MCMC conducted no reviews for two MCPs within three years of the review dates for this report (July 1, 2013, through June 30, 2014). The most recent review for one of the MCPs (a full-scope MCP) was well outside the three-year time period (September 2009), and the most recent review for the other MCP (a specialty MCP) was just outside the three-year time period (June 2010). As part of the process for producing the 2013–14 MCP-specific evaluation reports, HSAG received information from DHCS on surveys, audits, and reviews conducted for MCPs. New information was received for seven MCPs. While all MCPs had findings, all MCPs also 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.

Following is a summary of the status of the reviews conducted during the 2013–14 reporting period:

- Three MCPs were required to submit a CAP. Two of those CAPs were closed since the MCPs fully resolved all deficiencies, and resolution of one CAP remained in progress during the reporting period.

[21] MCPs are given the opportunity to self-report progress made on deficiencies when reviewing the results reported in plan-specific evaluation reports; however, DHCS does not respond to MCP self-reports. Deficiency corrections are addressed within the audit process or in DMHC or DHCS close-out letters.

- One MCP provided documentation to DHCS regarding actions taken to resolve three deficiencies identified through its DMHC SPD medical survey, and DHCS indicated that all deficiencies were fully resolved.
- One MCP documented actions to resolve deficiencies identified through its most recent DMHC routine medical survey; however, DHCS indicated that not enough time had elapsed for DHCS to determine if the deficiencies were fully resolved.
- DMHC identified several deficiencies for one MCP during its SPD medical survey, and resolution of those deficiencies remained in progress during the reporting period.
- DHCS A&I identified several findings for one MCP during its medical audit, and resolution of those findings remained in progress during the reporting period.

As has been true in previous years, the areas with the most opportunities 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. Below, HSAG summarizes the findings within the review areas with multiple findings across MCPs. Note that since there were only seven MCPs with new review information during the review period, most findings were individual to each MCP.

Please note that based on the information in the compliance reports from DHCS, HSAG cannot determine if the MCMC reviews included in the 2013–14 reporting period included a comprehensive assessment of the MCPs' compliance with all federal and State requirements.

Access and Availability/Access and Availability of Services

- MCPs had processes designed to ensure MCMC beneficiaries have access to needed health care services.
- Not all MCPs displayed the required provider accessibility indicator information on their websites.
- Not all MCPs had all required access and availability policies and procedures.

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

- 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.
- Not all MCPs included the required member rights information in their member handbook and evidence of coverage documents.
- Not all MCPs informed members of their rights regarding independent medical review and their right to contact DHCS when filing grievances requiring expedited review.

Quality Management/Quality Improvement System

- As in prior years, the 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.
- Not all MCPs had required monitoring and oversight processes to ensure quality of care problems are identified and resolved.

Utilization Management

- All MCPs appear to be implementing 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.

Conclusions

Taking into account the findings for the seven MCPs with new review information, the MCPs were partially compliant with most of the standards and had findings in multiple areas. Although the MCPs had challenges meeting all requirements, they 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 CAP process or by providing documentation of the actions taken to resolve the findings as part of DHCS's follow-up process. As part of HSAG's process for developing the 2013–14 MCP-specific evaluation reports, several MCPs provided documentation of actions taken to correct unresolved findings noted in their 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 physical accessibility indicator information is displayed on their websites.
- Ensure that access and availability policies and procedures are developed, implemented, and monitored.
- Ensure that all required member rights information is communicated through the member handbook, evidence of coverage documents, and grievance resolution letters.
- Develop and implement monitoring and oversight processes to ensure quality of care problems are identified and resolved.
- Ensure that utilization management policies and procedures are developed, implemented, and monitored.

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

- Ensure a comprehensive audit is conducted at least once within a three-year period with all MCPs.

DHCS's documentation of actions taken in response to HSAG's 2012–13 external quality review recommendations are included in Appendix D.

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 performance measures specific to the External Accountability Set when calculating rates.

Conducting the Review

Each full-scope MCP calculated and reported MCP-specific data for the following DHCS-selected measures in the 2014 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 Inhibitors or ARBs*
- *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 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *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)

- *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.
- *School Attendance*: The number of capitated Medi-Cal managed care members enrolled into Family Mosaic Project with a 2 or 3 in school attendance on the initial Child and Adolescent Needs and Strengths (CANS) outcome/assessment tool and a 2 or 3 in school attendance on the most recent closing CANS during the measurement period.

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. Additionally, DHCS did not establish an MPL or HPL for the *All-Cause Readmissions* measure, which is a non-HEDIS measure used for the *All-Cause Readmissions* collaborative QIP.

DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, a lower rate indicates better performance, and a higher 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 (IP) 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™[22] (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 for 2011–14 (as available) and compares the current year's rates 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 2014 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 the MCPs reporting their rates. MCPs typically calculated their 2014 HEDIS rates with measurement data from January 1, 2013, to December 31, 2013, with the exception of some measures that deviate slightly from this measurement period.

[22] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Performance measure calculation and reporting typically involves three phases: Off-site, On-site, and Post-on-site.[23]

Off-site Activity (October through March)

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

On-site Activity (January through April)

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

Post-on-site Activity (May through October)

- MCPs submit final audited rates to DHCS (June).

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

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

Data Collection Methodology

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

Administrative Method

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

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

- *All-Cause Readmissions* (statewide collaborative QIP measure)
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Ambulatory Care—Outpatient Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Breast Cancer Screening*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *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*
- *School Attendance*
- *Use of Imaging Studies for Low Back Pain*

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

Hybrid Method

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

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

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

Following are the 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, currently only two of the MCMC-contracted MCPs report rates in this manner, Kaiser North and Kaiser South. The Kaiser MCPs have IS capabilities, primarily due to their closed-system model and electronic medical records that support administrative-only reporting because medical record review does not generally yield additional data beyond what the MCP had already captured administratively.

HSAG computed the 2014 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 that were given an audit result of *Not Reportable* were not included in the calculation of these averages. A weighted average is a better estimate of care for all MCMC beneficiaries than a straight average of MCMC MCPs' performance.

Findings

Performance Measure Validation Results

Twenty-five of the 26 contracted MCPs underwent performance measure validation. HSAG did not conduct an NCQA HEDIS Compliance Audit with California Health & Wellness in 2014 since the MCP's members did not meet continuous enrollment criteria. HSAG will include California Health & Wellness and all expansion counties covered by the other MCMC MCPs in the 2015 NCQA HEDIS Compliance Audit process. 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.[24]

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

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.

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

Most of the challenges and opportunities were MCP-specific, and few challenges were applicable to all or most of the MCPs. However, the use of supplemental databases for HEDIS reporting increased, which required the MCPs to increase coordination and oversight efforts to ensure that

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

these databases met the HEDIS reporting requirements, including the completion of a separate Section 5 of the HEDIS Roadmap document. In addition, some MCPs did not require that a rendering provider be included on claims and encounters.

A few MCPs still receive paper claims and continue to be challenged in convincing some providers to submit electronic claims instead of paper claims. A few MCPs also had challenges with their vendors in terms of timelines and accuracy.

Recommendations

Based on the results of the 2014 HEDIS 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 PCP for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, *Weight Assessment and Counseling for Nutrition and Physical Activity*, and *Children and Adolescent's Access to Primary Care Practitioners*; and for the identification of a nephrologist, optometrist, and ophthalmologist for the *Comprehensive Diabetes Care* measures. Improving capture of the rendering provider can decrease the burden of medical record review for measures that allow for hybrid reporting.
- Focus on obtaining more complete and accurate administrative data and decreasing the use of supplemental databases (due to changes with nonstandard supplemental database requirements). In lieu of standard supplemental data or administrative data, medical record review is preferable to augment hybrid measures, rather than nonstandard databases. The requirements for nonstandard databases are now more stringent than for medical record review, and failure to follow the requirements could invalidate the nonstandard database.
- Closely monitor timelines, milestones, and deliverables of contracted providers and software vendors. MCPs should consider implementing sanctions for vendors that do not meet contractual requirements.
- Review Roadmap responses provided by the vendor as well as the MCP's Roadmap to be certain that the process reflected is comprehensive and accurate.
- Improve reporting accountability by clearly documenting the internal data audit processes.
- Coordinate the HEDIS rate review quality assurance process with the vendor to ensure accuracy of the rates produced periodically by the vendor.
- Document in detail any changes in software, vendor, or any testing or implementation process.

Performance Measure Results for Full-Scope Managed Care Health 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 provides four-year trending information (as available) for the MCMC weighted averages for the required External Accountability Set measures. Table 5.1 also shows the MCMC weighted average compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray. MCP-specific rates for each measure are included in Appendix A.

Table 5.1—2011–14 Trend Table for Statewide Medi-Cal Managed Care Weighted Average Performance Measure Results for Full-Scope Managed Care Health Plans

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.43%	14.17%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	39.64	43.15	42.06	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	273.09	283.14	298.16	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**81.49%**	**80.77%**	**84.15%**	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	**86.44%**	**86.91%**	87.78%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**80.44%**	**80.54%**	83.86%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	26.85%	25.32%	29.96%	27.94%	↓
Cervical Cancer Screening	Q,A	—	—	—	63.69%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	74.92%	78.15%	77.25%	75.07%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	95.74%	**94.42%**	**95.25%**	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	87.13%	**84.89%**	**86.27%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**86.88%**	**85.89%**	**86.08%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**85.82%**	**85.62%**	**82.90%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	64.58%	67.49%	63.20%	60.25%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	50.46%	55.52%	51.32%	50.69%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	83.64%	84.20%	83.19%	83.13%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	49.22%	50.79%	49.35%	46.64%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	39.36%	40.51%	38.27%	38.16%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	79.15%	79.44%	78.54%	78.26%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	80.49%	81.90%	81.80%	82.65%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	40.21%	38.04%	40.35%	43.73%	▼
Controlling High Blood Pressure	Q	—	—	58.30%	56.34%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	62.99%	72.66%	74.44%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	58.85%	53.48%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	36.52%	32.23%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	61.52%	61.74%	**58.61%**	**56.99%**	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.65%	83.77%	83.17%	81.33%	↔
Use of Imaging Studies for Low Back Pain	Q	80.43%	81.03%	80.84%	80.35%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	60.87%	68.33%	71.55%	71.17%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	66.31%	72.08%	72.53%	71.37%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	49.79%	56.04%	58.28%	59.53%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	77.14%	76.77%	74.50%	73.29%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on comparing the 95-percent confidence levels associated with 2013 and 2014 rates.
* Member months are a member's "contribution" to the total yearly membership.
‡ This is a utilization measure, which is not assigned a domain of care.
— Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.

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

Seniors and Persons with Disabilities Performance Measure Stratification

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[25] 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.[26]

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

[25] 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 health plan and for the subset of enrollees who are Seniors and Persons with Disabilities. Managed care health 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.

[26] 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.

- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 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*

Full-Scope Managed Care Health Plan Performance Measure Result Findings

Consistent with 2013, MPLs and HPLs were not established for the following measures:

- *All-Cause Readmissions*—developed for the statewide collaborative QIP
- *Ambulatory Care*—utilization measures
  - *Outpatient Visits*
  - *Emergency Department Visits*

Additionally, although MPLs and HPLs were established for the following measures, DHCS did not hold the MCPs accountable to meet the MPLs for these measures for 2014:

- All four *Children and Adolescents' Access to Primary Care Practitioners* measures—to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact.
- *Cervical Cancer Screening*—because NCQA made changes to the specifications for HEDIS 2014 to reflect the new screening guidelines. As a result, this measure was treated as a first year measure for HEDIS 2014.
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* and *LDL-C Screening* measures—because NCQA removed these measures from the HEDIS measure set beginning with HEDIS 2015.

For the following measures, 2014 was the first year DHCS held the MCPs accountable to meet the MPLs:

- *Controlling High Blood Pressure*

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

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

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

The MCMC weighted average for five measures improved significantly from 2013 to 2014, compared to three measures from 2012 to 2013. When compared to 2013, the MCMC weighted averages for seven measures were significantly worse in 2014, compared to four measures from 2012 to 2013. The performance comparison results show that overall, MCMC had more measures with significant improvement in 2014 when compared to 2013 and more measures with weighted average rates that were significantly worse in 2014 when compared to 2013.

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

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

High and Low Plan Performers

Three MCPs demonstrated high performance across the EAS, exceeding 14 or more of DHCS's established HPLs, and only one of these MCPs had measures with rates below the MPLs. These MCPs were also among the top-performing MCPs in 2013:

- Kaiser North—Sacramento County: 22 measures with rates above the HPLs, and two measures with rates below the MPLs.

- Kaiser South—San Diego County: 20 measures with rates above the HPLs, and no measures with rates below the MPLs.
- San Francisco Health Plan—San Francisco County: 14 measures with rates above the HPLs, and no measures with rates below the MPLs.

Thirteen MCP counties showed the greatest opportunity for improvement by having 10 or more measures below the DHCS-established MPLs:

- Alameda Alliance for Health—Alameda County (10 measures)
- Anthem Blue Cross Partnership Plan—Alameda County (22 measures), Contra Costa County (16 measures), Fresno County (13 measures), Kings County (19 measures), and Sacramento County (15 measures)
- Cal Viva Health—Kings County (14 measures)
- Care1st Partner Plan—San Diego County (11 measures)
- Health Net Community Solutions, Inc.—Kern County (16 measures), Sacramento County (16 measures), and San Diego County (12 measures). (Note: The rates for 15 measures were below the MPLs in San Joaquin County; however, 2014 was the first year Health Net Community Solutions, Inc., reported rates for San Joaquin County and DHCS therefore did not hold the MCP accountable to meet the MPLs for this county.)
- Molina Healthcare of California Partner Plan, Inc.—Sacramento County (13 measures)

It is important to note that MPLs and HPLs represent national benchmarks based on rates reported by health plans across the nation. While a comparison of MCP performance to the HPL or MPL allows one to compare performance against health plan performance nationally, this type of comparison does not take into account the actual rate of performance. Therefore, while an MCP may perform at or above the HPL, there could still be significant opportunities for improvement. For example, if an MCP exceeding the HPL had a childhood immunization rate of 30 percent, despite exceeding the HPL, the performance may still be considered suboptimal. Conversely, while an MCP may perform at or below the MPL, the MCP's performance may be viewed as satisfactory. For example, if an MCP is below the MPL for access to preventive services with a rate of 90 percent, despite falling below the MPL, the MCP may be viewed as within an acceptable rate of performance.

Model Type Performance

Consistent with 2013, the COHS model outperformed the GMC model and Two-Plan Model TPM types on 24 of the 30 performance measures. (Note: HSAG does not make comparisons for the two *Ambulatory Care* measures because they are utilization measures. The GMC model outperformed the other models on five measures, and the TPM outperformed the other model types on the remaining one measure).

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

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 IP to DHCS. The purpose of an IP is to develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act cycle . DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP had an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates (measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

MCPs with *Cervical Cancer Screening* rates below the MPLs in 2013 were not 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. Additionally, 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 would not be required to submit an IP for either measure, and MCPs using these

measures as QIP indicators would not be required to report on the indicators in 2013 or beyond. This decision was made based on new cholesterol management guidelines being released[27] and because NCQA removed these measures from the HEDIS measure set beginning with HEDIS 2015.

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid-cycle approach (including the PDSA cycle) to strengthen these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

HEDIS Improvement Plans Findings

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information.

Unlike in previous years, most MCPs' IPs for measures with rates below the MPLs were not successful at bringing the rates to above the DHCS-established MPLs. For some measures, the MCPs' efforts resulted in the rates improving significantly; however, the improvement was not enough to bring the rates from below the MPLs to above the MPLs. While the rates remained below the MPLs, the improvement shows that the MCPs are implementing strategies that will likely result in the rates eventually improving to meet or exceed DHCS's minimum performance requirements.

One MCP, Anthem Blue Cross Partnership Plan, continued to implement a CAP to address the MCP's poor performance on many measures across all counties. As part of the CAP, the MCP was required to implement QIPs, IPs, and PDSA cycles. While Anthem Blue Cross Partnership Plan made some progress, the MCP's performance continued to be below DHCS's minimum performance requirements for many measures across all counties.

During the review period for this report, DHCS required some MCPs to submit PDSA cycles in conjunction with their IPs. The MCPs were to conduct a small test of change using the PDSA

[27] 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. Accessed on: February 12, 2015.

cycle as a way to focus improvement efforts for measures with rates below the MPLs and to test the change within a short period of time (e.g., three months). By assessing for change in a short time frame, the MCPs could quickly learn whether strategies should be expanded, modified, or eliminated.

HSAG's review of the MCP's improvement strategies found that the MCPs did not narrow the focus of their improvement efforts and instead attempted to address too many barriers with multiple interventions. Since the MCPs did not narrow the focus of their quality improvement strategies, it was difficult for the MCPs to determine which efforts were successful and which were not.

Seniors and Persons with Disabilities Result Findings

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

Specialty Managed Care Health Plan Performance Measure Result Findings

AIDS Healthcare Centers

AIDS Healthcare Centers reported rates for the *Controlling High Blood Pressure* and *Colorectal Cancer Screening* measures. The rate for the *Controlling High Blood Pressure* measure showed no statistically significant change from 2013 to 2014 and remained above the MPL. The rate declined significantly from 2013 to 2014 for the *Colorectal Cancer Screening* measure, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014.

Family Mosaic Project (non-HEDIS measures)

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

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

- *School Attendance*: The number of capitated Medi-Cal managed care members enrolled into Family Mosaic Project with a 2 or 3 in school attendance on the initial CANS outcome/assessment tool and a 2 or 3 in school attendance on the most recent closing CANS during the measurement period.

The rate of *Out-of-Home Placements* dropped by less than 1 percentage point from 2013 to 2014. The percentage decrease in the rate for this measure reflected an improvement in performance, although the change was not statistically significant. Since 2014 was the first year Family Mosaic Project reported the *School Attendance* measure, HSAG could conduct no analysis or comparison for the measure.

SCAN Health Plan

SCAN Health Plan reported rates for the *Breast Cancer Screening* and *Osteoporosis Management in Women Who Had a Fracture* measures. While the rate declined significantly from 2013 to 2014 for the *Breast Cancer Screening* measure, the rate was above the HPL for the third consecutive year (Note: In 2012, DHCS did not hold the MCP accountable to meet the MPL since 2012 was the first year the MCP reported this measure.). The rate improved significantly from 2013 to 2014 for the *Osteoporosis Management in Women Who Had a Fracture* measure.

Conclusions

DHCS demonstrates a continued commitment to monitor and improve the quality of care delivered to its MCMC beneficiaries through development of an External Accountability Set that supports MCMC's overall quality strategy. Consistent with 2013, most of the Medi-Cal weighted averages were at or between the 25th and 74th national Medicaid percentiles; however, there was a greater percentage of weighted averages in this range in 2014—66 percent compared to 46 percent in 2013.

DHCS implements 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. DHCS made no modifications to the auto-assignment measures in 2014; however, in 2015, the *Controlling High Blood Pressure* measure will be added to the auto-assignment program.
- DHCS evaluates its External Accountability Set and auto-assignment program measures annually to rotate measures based on MCP performance and program needs. This process allows DHCS to identify and select new measures as opportunities for improvement.
- DHCS conducts comprehensive oversight of the MCPs' performance and works closely with MCPs that have demonstrated poor performance over several years on multiple measures.

- DHCS supports 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 actively reviews 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.

In addition to the mechanisms listed above, DHCS worked closely with MCPs that were implementing IPs to support them in implementing rapid-cycle improvement processes. DHCS interacted regularly with MCPs having multiple rates below the MPLs to ensure the MCPs were implementing improvement strategies that would increase the likelihood of positive outcomes.

Recommendations

Based on the review of the 2014 HEDIS results, HSAG provides the following recommendations to the MCPs for improving performance:

- MCPs should identify the priority barriers based on available data and link improvement strategies to the barriers having the greatest negative effect on the targeted HEDIS rate.
- MCPs should limit the number of interventions to a number that allows for the ability to track and monitor interventions and critically evaluate intervention effectiveness. By limiting the number of interventions, the MCPs will be better able to identify the interventions that have been successful, those that should be modified, and those that should be discontinued.
- 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 should consider working with MCMC and the EQRO as sources of more intensive technical assistance for measures that continue to demonstrate low performance over consecutive years.

Based on the review of the 2014 HEDIS results and MCMC's monitoring and oversight processes related to the MCPs' performance, HSAG has no specific recommendations for MCMC regarding its oversight of the MCPs' performance on External Accountability Set measures.

DHCS's documentation of actions taken in response to HSAG's 2012–13 external quality review recommendations are included in Appendix D.

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 quality improvement.
- 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[28] 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 improvements that result from the QIP.

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.

[28] 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. Accessed on: February 19, 2013.

Instead, specialty MCPs are required to design and maintain two internal QIPs (IQIPs) 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.[29] If a QIP receives an overall *Partially Met* or *Not Met* validation status, the MCP must address the areas of noncompliance and resubmit the QIP until the QIP achieves an overall *Met* validation status.

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

[29] 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. Accessed on: February 19, 2013.

to make the process more efficient. Placing greater emphasis on improving QIP outcomes increases the likelihood of improved member health, functional status, and satisfaction.

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*, or *Not Met*. The scoring methodology also includes a *Not Applicable (NA)* 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. To ensure a sound and effective review, HSAG designates some of the elements as critical elements. All critical elements must achieve a *Met* score for the QIP to produce valid and reliable results.

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, 2013, through June 30, 2014. 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

The *All-Cause Readmissions (ACR)* statewide collaborative QIP was in the Implementation stage during the review period. The *ACR* QIP submissions and the MCP IQIP submissions were scored according to the approved protocol. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status; however, several IQIPs were closed during the reporting period without achieving a *Met* validation status. Table 6.1 summarizes the reasons the IQIPs were closed.

Table 6.1—IQIPs Closed during the Reporting Period Prior to Achieving a *Met* Validation Status

MCP Name	IQIP Name	Reason for QIP Closure
Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, and Madera counties	*Improving Diabetes Management*	As part of the MCP's CAP, DHCS instructed the MCP to close this QIP and implement a new diabetes QIP.
Anthem Blue Cross Partnership Plan—Sacramento, San Francisco, Santa Clara, and Tulare counties	*Improving HEDIS Postpartum Care Rates*	As part of the MCP's CAP, DHCS instructed the MCP to close this QIP and implement a new prenatal and postpartum QIP.
CalOptima—Orange County	*Improving the Rates of Cervical Cancer Screening*	The HEDIS specifications for the *Cervical Cancer Screening* measure changed.
Family Mosaic Project—San Francisco County	*Increase the Rate of School Attendance*	The MCP inaccurately documented the measurement periods and the data were invalid.
Health Net Community Solutions, Inc.—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties	*Improving Cervical Cancer Screening Among Seniors and Persons with Disabilities*	The HEDIS specifications for the *Cervical Cancer Screening* measure changed and the MCP had a large influx of SPD members.
Inland Empire Health Plan—Riverside/San Bernardino counties	*Attention Deficit Hyperactivity Disorder (ADHD) Management*	ADHD is no longer a priority topic for the MCP.
Santa Clara Family Health Plan—Santa Clara County	*Childhood Obesity Partnership and Education*	The MCP changed the methodology between baseline and Remeasurement 1.

In addition to the IQIPs in Table 6.1 that were closed prior to achieving a *Met* validation status, AIDS Healthcare Foundation—Los Angeles County closed its *CD4 and Viral Load Testing* IQIP because changes were made to the clinical guidelines. Because the topic is still a priority for AIDS Healthcare Foundation, the MCP implemented a new IQIP with the same topic that incorporated the new guidelines.

Table 6.2 summarizes the validation results for all statewide collaborative QIP and IQIP submissions across CMS protocol activities during the review period, and Table 6.3 summarizes the validation results for all statewide collaborative QIP and IQIP resubmissions across CMS protocol activities during the review period. Results in Table 6.2 are averaged across submissions

and across resubmissions in Table 6.3. Please note that all QIPs were assessed for Activities I through VI, but not all QIPs were assessed for Activities VII through X since some QIPs had not yet progressed to the Implementation and/or Outcomes stages. Additionally, the aggregated percentages in Table 6.1 and Table 6.2 include scores from the IQIPs that were closed prior to achieving a *Met* validation status.

Table 6.2—Initial QIP Submissions
Validation Results from July 1, 2013, through June 30, 2014*
(Number = 124 QIP Submissions from 25 MCPs, in 30 Counties)

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)	95%	5%	0%
	III: Clearly Defined Study Indicator(s)**	95%	4%	0%
	IV: Correctly Identified Study Population	95%	4%	1%
	V: Valid Sampling Techniques (if sampling is used)**	95%	2%	2%
	VI: Accurate/Complete Data Collection**	85%	9%	7%
Design Total		**92%**	**5%**	**3%**
Implementation	VII: Sufficient Data Analysis and Interpretation	72%	10%	18%
	VIII: Appropriate Improvement Strategies	41%	51%	8%
Implementation Total		**62%**	**23%**	**15%**
Outcomes	IX: Real Improvement Achieved	37%	7%	56%
	X: Sustained Improvement Achieved	80%	0%	20%
Outcomes Total		**38%**	**7%**	**55%**

*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 for each QIP.

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

Table 6.3—QIP Resubmissions
Validation Results from July 1, 2013, through June 30, 2014*
(Number = 95 QIP Submissions from 25 MCPs, in 30 Counties)

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	99%	1%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	99%	1%	0%
	IV: Correctly Identified Study Population	99%	0%	1%
	V: Valid Sampling Techniques (if sampling is used)	99%	1%	0%
	VI: Accurate/Complete Data Collection	97%	2%	1%
Design Total		**98%**	**1%**	**1%**
Implementation	VII: Sufficient Data Analysis and Interpretation	89%	6%	5%
	VIII: Appropriate Improvement Strategies	84%	15%	1%
Implementation Total		**87%**	**9%**	**4%**
Outcomes	IX: Real Improvement Achieved	28%	4%	68%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**28%**	**4%**	**68%**

*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 resubmissions for each QIP.

Design

The Design stage includes QIP validation findings for Activities I through VI. For the initial QIP submissions, the MCPs demonstrated a strong application of the Design stage, meeting 92 percent of the requirements for all applicable evaluation elements within this study stage. The MCPs demonstrated an excellent application of Activities I through V by selecting an appropriate topic, clearly defining their study questions and indicators, correctly identifying the study population, and using valid sampling techniques. As in previous years, the activity with the greatest opportunity for improvement was Activity VI, with MCPs meeting 85 percent of the requirements for all applicable evaluation elements for this activity. The deficiencies within this activity were related to some MCPs not providing a complete and accurate data analysis plan and not including a description of a defined and systematic process for collecting data.

During the resubmission process, the MCPs addressed most of the deficiencies identified during the initial submission validation process, resulting in the MCPs meeting 98 percent of the requirements for all applicable evaluation elements within the Design stage. The aggregated Activity VI score improved by 12 percentage points during the resubmission process, with MCPs meeting 97 percent of the requirements for all applicable evaluation elements for this activity.

Implementation

The Implementation stage includes QIP validation findings for Activities VII and VIII. For the initial QIP submissions, the MCPs struggled with their application of the Implementation stage, meeting 62 percent of the requirements for all applicable evaluation elements within this study stage.

Activity VII assesses whether the MCP's data analysis techniques comply with industry standards, appropriate statistical tests are used, and accurate/reliable information is obtained. For the initial QIP submissions, the average percentage of applicable elements in Activity VII with a *Met* score was 72 percent. The deficiencies within this activity were related to some MCPs not including an interpretation of the findings, not indicating if any factors threatened the internal or external validity of the findings, and not indicating if there was a statistical difference between the current measurement period and the baseline measurement period.

Activity VIII assesses if the barrier analysis is adequate to identify barriers to improvement, the MCP has developed appropriate improvement strategies, and the timeline for implementation of interventions is reasonable. For the initial QIP submissions, the average percentage of the applicable elements in Activity VIII with a *Met* score was 41 percent. Following are the main issues that caused poor performance on this activity:

- Most MCPs did not document that they conducted an annual causal/barrier and drill-down analysis in addition to periodic analyses of their most recent data.
- Most MCPs did not ensure that the interventions implemented for a specific barrier were relevant to that barrier and would directly impact study indicator outcomes.
- Most MCPs did not indicate having a process in place to evaluate the efficacy of the interventions to determine if they are having the desired effect.

During the resubmission process, the MCPs addressed most of the deficiencies identified during the initial submission validation process. The MCPs' average percentage of applicable elements with a *Met* score improved by 17 percentage points for Activity VII and by 43 percentage points for Activity VIII, resulting in the MCPs meeting 89 percent of the requirements for all applicable elements for Activity VII and 84 percent of the requirements for all applicable evaluation elements for Activity VIII.

Outcomes

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 28 QIPs that could be assessed for improvement, only eight QIPs achieved statistically significant improvement over baseline. All QIPs assessed for improvement were internal QIPs because the *ACR* QIP had not yet progressed to this stage. The validation results suggest that the

interventions that many of the MCPs are implementing are not resulting in positive outcomes. Additionally, review of the QIPs shows that the MCPs are not evaluating each of their interventions or conducting new causal/barrier analyses. Without a method to evaluate the effectiveness of interventions, the MCPs are limited in their ability to revise, standardize, or discontinue improvement strategies, which ultimately limits their success in affecting change in subsequent measurement periods.

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 eight QIPs that achieved statistically significant improvement over baseline, six were assessed for sustained improvement. Of the six assessed for sustained improvement, five achieved sustained improvement for at least one study indicator, and one did not achieve sustained improvement.

Overall, most QIPs were not successful at achieving the desired improved health outcomes for the QIPs' targeted members.

Quality Improvement Project Outcomes Findings

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

Internal Quality Improvement Projects

During the review period of July 1, 2013, through June 30, 2014, 28 IQIPs could be assessed for statistically significant improvement over baseline and six could be assessed for sustained improvement. Of the 28 IQIPs that could be assessed for statistically significant improvement over baseline, only eight achieved statistically significant improvement over the baseline period. Of the six QIPs assessed for sustained improvement, only five QIPs achieved sustained improvement, meaning that the statistically significant improvement achieved over baseline was maintained or increased in the current measurement period.

Table 6.4 displays the QIPs assessed for improvement 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 6.4—Internal Quality Improvement Projects Assessed for Project Outcomes from July 1, 2013, through June 30, 2014

MCP Name	QIP Name	Statistically Significant Improvement[1]	Sustained Improvement[2]
AIDS Healthcare Foundation	*Advance Care Directives*	Yes	Yes
AIDS Healthcare Foundation	*CD4 and Viral Load Testing*	No	Not Assessed
Alameda Alliance for Health	*Improving Anti-Hypertensive Medication Fills Among Members with Hypertension*	No	Not Assessed
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—Santa Clara County	*Improving HEDIS Postpartum Care Rates*	Yes	No
Anthem Blue Cross Partnership Plan—Tulare County	*Improving HEDIS Postpartum Care Rates*	Yes	Yes
CalOptima	*Improving the Rates of Cervical Cancer Screening*	Yes	Yes
Care1st	*Comprehensive Diabetic Care*	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
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 Net Community Solutions, Inc.—Tulare 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*	Yes	Yes
Kaiser South—San Diego County	*Children's Access to Primary Care Practitioners*	No	Not Assessed
Kern Family Health Care	*Comprehensive Diabetic Quality Improvement Plan*	No	Not Assessed

MCP Name	QIP Name	Statistically Significant Improvement[1]	Sustained Improvement[2]
L.A. Care Health Plan	*Improving HbA1c and Diabetic Retinal 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 Access to Primary Care for Children and Adolescents*	Yes	Not Assessed
Partnership HealthPlan of California—Sonoma County	*Improving Access to Primary Care for Children and Adolescents*	Yes	Not Assessed
Santa Clara Family Health Plan	*Childhood Obesity Partnership and Education**	No	Not Assessed
SCAN Health Plan	*Care for Older Adults*	Yes	Yes

[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.

*Although this QIP was assessed for overall improvement, no statistical comparison could be made between baseline and Remeasurement 1 because the MCP changed the methodology between measurement periods.

Following is a summary of the IQIPs that achieved sustained improvement for at least one study indicator during the review period.

Advance Care Planning

- AIDS Healthcare Foundation—The MCP sustained the significant increase in the percentage of eligible members with evidence of advance care planning or having a discussion regarding advance care planning with their provider, resulting in this IQIP being successfully closed.

Care for Older Adults

- SCAN Health Plan—The IQIP resulted in the MCP conducting significantly more functional status assessments and pain screenings with its members than in the previous measurement

period. Since the QIP had already achieved statistically significant improvement over baseline, the sustained improvement resulted in this IQIP being successfully closed.

Children and Adolescent Health

- Inland Empire Health Plan—The MCP sustained the significant increase in the percentage of eligible members who received a follow-up visit within 30 days after being prescribed a prescription for ADHD. Although the IQIP achieved the desired outcomes, it did not achieve a fully *Met* validation status before it was closed, as indicated in Table 6.1.
- Partnership HealthPlan of California—The QIP resulted in significantly improved access to primary care providers for children and adolescents aged 12 to 24 months in Napa/Solano/Yolo counties and for children and adolescents aged 25 months to 6 years, 7 to 11 years, and 12 to 19 years old in Napa/Solano/Yolo and Sonoma counties. The QIP will be assessed for sustained improvement in the next reporting period.

Women's Health

- Anthem Blue Cross Partnership Plan—In the previous reporting period, the QIP resulted in a significantly higher percentage of appropriately timed postpartum visits for women in Santa Clara and Tulare counties; however, during the current reporting period, the MCP was only able to sustain this improvement in Tulare County. Additionally, the rate for the study indicator remained below the DHCS-established MPL in three of the four counties included in the IQIP—Sacramento, Santa Clara, and Tulare counties. Only the rate in San Francisco County was above the MPL in the reporting period. As indicated in Table 6.1, DHCS instructed the MCP to close this QIP and implement a new prenatal and postpartum QIP as part of the MCP's CAP.
- CalOptima—As in previous years, the MCP continued to significantly increase the percentage of women who received a Pap test from the top 200 high-volume providers. Although the IQIP achieved the desired outcomes, it did not achieve a fully *Met* validation status before it was closed, as indicated in Table 6.1.

Conclusions

For the initial QIP submissions, the MCPs demonstrated an excellent application of the Design stage, as evidenced by the high percentage of QIPs receiving *Met* scores for the evaluation elements for Activities I through V; however, the MCPs only demonstrated a sufficient understanding of Activity VI. Upon resubmission, the MCPs improved their scores for all applicable evaluation elements within this study stage. The greatest opportunity for improvement in the Design stage is for the MCPs to provide a complete description of the data analysis plan and include a description of a defined and systematic process for collecting data during the initial QIP submission process.

For the initial QIP submissions, the MCPs demonstrated many opportunities for improvement within the Implementation stage, meeting 62 percent of the requirements for all applicable evaluation elements within this study stage. Upon resubmission, the MCPs improved their scores, meeting 87 percent of the requirements within this stage. The MCPs can improve their quality improvement efforts by conducting regular causal/barrier analyses and linking the results to the corresponding interventions to increase the likelihood that the interventions will result in statistically significant and sustained improvement. The MCPs would increase the likelihood of positive outcomes by developing processes to evaluate the effectiveness of implemented interventions to determine if the interventions are having the desired effect.

During the reporting period, only eight of the 28 QIPs that could be assessed for statistically significant improvement achieved statistically significant improvement over baseline. Of the six QIPs that could be assessed for sustained improvement, five achieved sustained improvement, meaning that the statistically significant improvement in performance achieved over baseline was maintained or increased in the current measurement period.

During the review period, MCMC, the MCPs, and HSAG had focused discussions about the importance of conducting regular causal/barrier analyses, identifying appropriate improvement strategies, and effectively evaluating each intervention. Discussions also focused on rapid-cycle improvement strategies and how the MCPs could incorporate these strategies into their QIP processes to increase the likelihood of positive outcomes. 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.

The MCPs did not provide all required documentation in their initial QIP submissions. All MCPs had to resubmit at least one QIP during the reporting period, with some MCPs needing to resubmit their QIP multiple times before the QIP achieved a *Met* validation status. The MCPs demonstrated many opportunities to improve the thoroughness and accuracy of the QIP documentation and would benefit from thoroughly reviewing the QIP Completion Instructions and validation feedback from HSAG to ensure meeting 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:

- To avoid having to resubmit their QIPs, implement strategies, including reviewing the QIP Completion Instructions and previous QIP validation tools, to ensure that all required documentation is included in the QIP Summary Form.
- Conduct routine causal/barrier analyses and include the documentation when submitting the QIP for validation.

- Ensure that the interventions implemented for a specific barrier are relevant to that barrier and will directly impact study indicator(s) outcomes.
- 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.
- 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 and MCMC's monitoring and oversight processes related to QIPs, HSAG has no specific recommendations for MCMC regarding its oversight of the MCPs' performance on QIPs. Regarding the QIP process, HSAG recommends that MCMC explore with the EQRO a redesigned QIP process that supports the MCPs in conducting QIPs using rapid-cycle techniques and a validation process that facilitates greater technical assistance to the MCPs and feedback throughout the rapid-cycle QIP process.

DHCS's documentation of actions taken in response to HSAG's 2012–13 external quality review recommendations are included in Appendix D.

Conducting the EQRO Review

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions for a managed care program. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. HSAG will include a summary of the aggregate results in the 2014–15 EQR technical report.

DHCS's documentation of actions taken in response to HSAG's 2012–13 external quality review recommendations are included in Appendix D.

8. 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.

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, 2014, for each MCP related to compliance monitoring standards within the CFR.

Findings and Conclusions for Compliance Standards

For the seven MCPs with new compliance review information, most had findings in multiple areas and were partially compliant with most of the standards. The 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 CAP process or by providing documentation of the actions taken to resolve the findings as part of DHCS's follow-up process. Three MCPs provided documentation of actions they took to correct unresolved findings noted in their 2012–13 MCP-specific evaluation reports as part of HSAG's process for developing the 2013–14 MCP-specific evaluation reports. As in 2013, 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 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 all required member rights information is communicated through the member handbook, evidence of coverage documents, and grievance resolution letters.
- Develop and implement monitoring and oversight processes to ensure quality of care problems are identified and resolved.
- Ensure that utilization management policies and procedures are developed, implemented, and monitored.

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

- Ensure a comprehensive audit is conducted at least once within a three-year period with all MCPs.

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

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

When comparing 2014 MCMC weighted averages to 2013, MCMC had more measures with significant improvement in 2014 and more measures with weighted averages that were significantly worse in 2014. Following is a summary of notable aggregate performance measure results:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
  - The MCMC weighted average improved significantly from 2013 to 2014, resulting in the rate moving from below the DHCS-established MPL (national Medicaid 25th percentile) in 2013 to above the MPL in 2014.
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measures
  - The MCMC weighted averages improved significantly from 2013 to 2014 for these measures; however, the rates remained below the DHCS-established MPLs (national Medicaid 25th percentiles) for the third consecutive year.
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* and *25 Months to 6 Years* measures
  - The MCMC weighted averages improved significantly for these measures; however, the rates remained below the DHCS-established MPLs (national Medicaid 25th percentiles) for the second consecutive year.
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* measure
  - The MCMC weighted average declined significantly from 2013 to 2014, and the rate remained below the DHCS-established MPL (national Medicaid 25th percentile) for the third consecutive year.
- *Prenatal and Postpartum Care—Postpartum Care*
  - The MCMC weighted average was below the DHCS-established MPL (national Medicaid 25th percentile) for the second consecutive year.
- Although the MCMC weighted averages exceeded the DHCS-established MPLs, the rates were significantly worse in 2014 when compared to 2013 for the following measures:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
  - Both *Medication Management for People with Asthma—Medication Compliance* measures

In response to W&I Code, Section 14182(b)(17),[30] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their 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.

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

Only two specialty MCPs, AHF Healthcare Centers and SCAN Health Plan, are held to DHCS-established MPLs for their required measures. For AHF Healthcare Centers, the rate declined significantly from 2013 to 2014 for the *Colorectal Cancer Screening* measure, resulting in the rate moving from above the DHCS-established MPL (national commercial 25th percentile because no Medicaid benchmarks are available for this measure) to below the MPL. For SCAN Health Plan, the rate for the *Breast Cancer Screening* measure was above the DHCS-established HPL (national Medicaid 90th percentile) for the third consecutive year.

Recommendations for Performance Measures

Based on the results of the 2014 HEDIS 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

[30] 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 health plan and for the subset of enrollees who are Seniors and Persons with Disabilities. Managed care health 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.

the identification of a PCP for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, *Weight Assessment and Counseling for Nutrition and Physical Activity*, and *Children and Adolescent's Access to Primary Care Practitioners*; and for the identification of a nephrologist, optometrist, and ophthalmologist for the *Comprehensive Diabetes Care* measures. Improving capture of the rendering provider can decrease the burden of medical record review for measures that allow for hybrid reporting.

- Focus on obtaining more complete and accurate administrative data and decreasing the use of supplemental databases (due to changes with nonstandard supplemental database requirements). In lieu of standard supplemental data or administrative data, medical record review is preferable to augment hybrid measures, rather than nonstandard databases. The requirements for nonstandard databases are now more stringent than for medical record review, and failure to follow the requirements could invalidate the nonstandard database.
- Closely monitor timelines, milestones, and deliverables of contracted providers and software vendors. MCPs should consider implementing sanctions for vendors that do not meet contractual requirements.
- Review Roadmap responses provided by the vendor as well as the MCP's Roadmap to be certain that the process reflected is comprehensive and accurate.
- Improve reporting accountability by clearly documenting the internal data audit processes.
- Coordinate the HEDIS rate review quality assurance process with the vendor to ensure accuracy of the rates produced periodically by the vendor.
- Document in detail any changes in software, vendor, or any testing or implementation process.

Based on the review of the 2014 HEDIS results, HSAG provides the following recommendations to the MCPs for improving performance:

- MCPs should identify the priority barriers based on available data and link improvement strategies to the barriers having the greatest negative effect on the targeted HEDIS rate.
- MCPs should limit the number of interventions to a number that allows for the MCPs to have the ability to track and monitor interventions and critically evaluate intervention effectiveness. By limiting the number of interventions, the MCPs will be better able to identify the interventions that have been successful, those that should be modified, and those that should be discontinued.
- 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 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 2014 HEDIS results and MCMC's monitoring and oversight processes related to the MCPs' performance, HSAG has no specific recommendations for MCMC regarding its oversight of the MCPs' performance on External Accountability Set measures.

Validation of Performance Improvement Projects

DHCS refers to performance improvement projects as QIPs. HSAG reviewed each MCP's QIPs to ensure that the MCPs designed, conducted, and reported projects in a methodologically sound manner. The validation process helped to confirm that the reported improvements resulted from the QIP.

HSAG reviews each QIP using the CMS validation protocol[31] 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 improvements that result from the QIP.

Findings and Conclusions for Performance Improvement Projects

For the initial QIP submissions, the MCPs demonstrated an excellent application 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. MCPs that were required to resubmit their QIPs corrected many of the deficiencies identified for this stage, resulting in improved scores. The greatest opportunity for improvement in the Design stage is for the MCPs to provide a complete description of the data analysis plan and include a description of a defined and systematic process for collecting data during the initial QIP submission process.

For the initial QIP submissions, the MCPs demonstrated many opportunities for improvement within the Implementation stage. MCPs that were required to resubmit their QIPs corrected many of the deficiencies identified for this stage, resulting in improved scores. One significant opportunity for improvement is in the area of conducting regular causal/barrier analyses and linking the results to the corresponding interventions to increase the likelihood that the interventions will result in statistically significant and sustained improvement. Additionally, MCPs

[31] 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. Accessed on: February 19, 2013.

would increase the likelihood of positive outcomes by developing processes to evaluate the effectiveness of implemented interventions to determine if the interventions are having the desired effect.

During the reporting period, only eight of the 28 QIPs that could be assessed for statistically significant improvement achieved statistically significant improvement over baseline. Of the six QIPs that could be assessed for sustained improvement, five achieved sustained improvement, meaning that the statistically significant improvement in performance achieved over baseline was maintained or increased in the current measurement period.

During the review period, MCMC, the MCPs, and HSAG had focused discussions about the importance of conducting regular causal/barrier analyses, identifying appropriate improvement strategies, and effectively evaluating each intervention. Discussions also focused on rapid-cycle improvement strategies and how the MCPs could incorporate these strategies into their QIP processes to increase the likelihood of positive outcomes. 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.

MCPs did not provide all required documentation in their initial QIP submissions. All MCPs had to resubmit at least one QIP during the reporting period, with some MCPs needing to resubmit their QIP multiple times before the QIP achieved a *Met* validation status. The MCPs demonstrated many opportunities to improve the thoroughness and accuracy of the QIP documentation and would benefit from thoroughly reviewing the QIP Completion Instructions and validation feedback from HSAG to ensure meeting 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:

- To avoid having to resubmit their QIPs, implement strategies, including reviewing the QIP Completion Instructions and previous QIP validation tools, to ensure that all required documentation is included in the QIP Summary Form.
- Conduct routine causal/barrier analyses and include the documentation when submitting the QIP for validation.
- Ensure that the interventions implemented for a specific barrier are relevant to that barrier and will directly impact study indicator(s) outcomes.
- 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.
- 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 and MCMC's monitoring and oversight processes related to QIPs, HSAG has no specific recommendations for MCMC regarding its oversight of the MCPs' performance on QIPs. Regarding the QIP process, HSAG recommends that MCMC explore with the EQRO a redesigned QIP process that supports the MCPs in conducting QIPs using rapid-cycle techniques and a validation process that facilitates greater technical assistance to the MCPs and feedback throughout the rapid-cycle QIP process.

Optional External Quality Review Activities

Validation of Encounter Data

As indicated in Section 7 of this report (Encounter Data Validation), although HSAG conducted medical record review activities during the review period for this report, the results and analyses were not available at the time this report was written. HSAG will include a summary of the aggregate results in the 2014–15 EQR technical report.

Recommendations across All Activities

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

- Report outcomes achieved through strategies outlined in the *Medi-Cal Managed Care Program Quality Strategy Report* and indicate whether strategies will be expanded, modified, or eliminated to achieve improvement in key focus areas.

9. 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 or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure 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 for enrollees through its structural and operational characteristics and 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 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 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 2014 quality-related performance measure weighted average rates (which reflect 2013 measurement data), and QIP outcome results for QIPs falling into the quality domain of care 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 2014 performance measure rates. As was true in 2013, no weighted average rates exceeded the DHCS-established HPLs for measures falling into the quality domain of care. Following is a summary of notable aggregate results for measures falling into the quality domain of care:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
  - The MCMC weighted average improved significantly from 2013 to 2014; however, the rate remained below the DHCS-established MPL (national Medicaid 25th percentile) for the third consecutive year.
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
  - The MCMC weighted average improved significantly from 2013 to 2014, resulting in the rate moving from below the DHCS-established MPL (national Medicaid 25th percentile) in 2013 to above the MPL in 2014.
- *Prenatal and Postpartum Care—Postpartum Care*
  - The MCMC weighted average was below the DHCS-established MPL (national Medicaid 25th percentile) for the second consecutive year.
- Although the MCMC weighted averages exceeded the DHCS-established MPLs, the rates were significantly worse in 2014 when compared to 2013 for the following quality measures:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
  - Both *Medication Management for People with Asthma—Medication Compliance* measures

Overall, MCMC's performance related to required quality measures was average, meaning that most of the measures' weighted average rates were above the MPLs and below the HPLs. The performance comparison results show that MCMC had a similar number of quality measures with significant improvement in 2014 when compared to 2013 (two and three, respectively) and a similar number of quality measures with weighted average rates that were significantly worse in 2014 when compared to 2013 (six and five, respectively).

Most MCPs' IPs for quality measures with rates below the MPLs in 2013 were not successful at improving the rates to above the MPLs in 2014. For some measures, the MCPs' efforts resulted in the rates improving significantly; however, the improvement was not enough to bring the rates from below the MPLs to above the MPLs. The improvement shows that the MCPs are implementing strategies that will likely result in the rates eventually improving to meet or exceed DHCS's minimum performance requirements.

Consistent with 2013, the SPD rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics* measure, which falls into the quality domain of care, were significantly better than the non-SPD rates. For the second consecutive year, the SPD rates for the *All-Cause Readmissions* measure, which falls into the quality domain of care, were significantly higher when compared to the non-SPD rates. This is 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. All eight *Comprehensive Diabetes Care* measures fall into the quality domain of care, and the SPD rates for all the measures, except *Blood Pressure Control (<140/90 mm Hg)*, were better than the non-SPD rates. As was noted in 2013, having better SPD rates 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.

Twenty-six 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 one of them achieved statistically significant improvement over baseline. Five of the QIPs were assessed for sustained improvement, and four of them achieved sustained improvement for at least one of the study indicators. As has been true in previous years, once a QIP achieves statistically significant improvement, the MCPs are often able to maintain or improve upon the positive outcomes. While the QIPs demonstrated some positive outcomes related to the quality of care being delivered to MCMC members, MCPs continued to show many opportunities for improvement related to their approaches to achieving positive outcomes.

Access

The access domain of care relates to the standards set forth by the State that an MCP must meet 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, MMCD 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 2014 access-related performance measure weighted average rates (which reflect 2013 measurement data), and QIP outcome results for QIPs falling into the access domain of care 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 the findings were related to the MCPs not having all required access policies and procedures or MCPs not displaying required provider accessibility indicator information on their websites.

As was true in 2013, no weighted average rates exceeded the DHCS-established HPLs for measures falling into the access domain of care. Following is a summary of notable aggregate results for measures falling into the access domain of care:

- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* and *25 Months to 6 Years*
  - The MCMC weighted average improved significantly from 2013 to 2014 for both measures; however, the rates remained below the DHCS-established MPL (national Medicaid 25th percentile) for the second consecutive year.
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
  - The MCMC weighted average improved significantly from 2013 to 2014; however, the rate remained below the DHCS-established MPL (national Medicaid 25th percentile) for the third consecutive year.

- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
  - The MCMC weighted average declined significantly from 2013 to 2014, and the rate remained below the DHCS-established MPL (national Medicaid 25th percentile) for the third consecutive year.
- *Prenatal and Postpartum Care—Postpartum Care*
  - The MCMC weighted average was below the DHCS-established MPL (national Medicaid 25th percentile) for the second consecutive year.

In 2014, MCMC had five access measures with weighted average rates that were below the MPLs, which is the same number as 2013. The performance comparison results show that MCMC had more access measures with significant improvement in 2014 when compared to 2013 (three and one, respectively) and fewer measures with weighted averages that were significantly worse (one and seven, respectively).

Most MCPs' IPs for access measures with rates below the MPLs in 2013 were not successful at improving the rates to above the MPLs in 2014. For some measures, the MCPs' efforts resulted in the rates improving significantly; however, the improvement was not enough to bring the rates from below the MPLs to above the MPLs. The improvement in these rates shows that the MCPs are implementing strategies that will likely result in the rates eventually improving to meet or exceed DHCS's minimum performance requirements.

The *All-Cause Readmissions* measure falls into the access domain of care. As noted above, for the second consecutive year the SPD population had a significantly higher rate of readmissions than the non-SPD population, which is expected based on the greater and often more complicated health needs of these members. Additionally, the SPD rates for several MCP counties were significantly lower than the non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners* measures, which fall into the access domain of care. 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 PCP. As indicated above, the overall rates for the SPD population were better than the rates for the non-SPD population for seven of 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.

Twenty-six QIPs that progressed to the Outcomes stage fall into the access domain of care. Twenty-two of the QIPs were assessed for statistically significant improvement, and only two of them achieved statistically significant improvement over baseline. Four of the QIPs were assessed for sustained improvement, and three of them achieved sustained improvement for at least one of

the study indicators. As indicated above, once a QIP achieves statistically significant improvement, the MCPs are often able to maintain or improve upon the positive outcomes. While the QIPs demonstrated some positive outcomes related to the MCMC members' access to needed health care services, the MCPs continued to show many opportunities for improvement related to their approaches to improving access to care for members.

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 2014 timeliness-related performance measure weighted average rates (which reflect 2013 measurement data), and QIP outcome results for QIPs falling into the timeliness domain of care to assess MCMC's performance related to this domain.

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. As was true in 2013, 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 were related to MCPs not including the required member rights information in their member documents or MCPs not informing members of their rights regarding independent medical review and their right to contact DHCS when filing grievances requiring expedited review.

As was true in 2013, MCMC's performance related to required timeliness measures was average, meaning that most of the measures' weighted average rates were above the MPLs and below the HPLs. The weighted average rate for one timeliness measure, *Prenatal and Postpartum Care—Postpartum Care*, was below the DHCS-established MPL for the second consecutive year.

Most MCPs' IPs for timeliness measures with rates below the MPLs in 2013 were not successful at improving the rates to above the MPLs in 2014. For some measures, the MCPs' efforts resulted in the rates improving significantly; however, the improvement was not enough to bring the rates from below the MPLs to above the MPLs. The improvement in these rates shows that the MCPs are implementing strategies that will likely result in the rates eventually improving to meet or exceed DHCS's minimum performance requirements.

Five QIPs that progressed to the Outcomes stage fall into the timeliness domain of care. Three of the QIPs were assessed for statistically significant improvement, and none of them achieved statistically significant improvement over baseline. Two of the QIPs were assessed for sustained improvement, and one of them achieved sustained improvement for at least one of the study indicators. As indicated above, once a QIP achieves statistically significant improvement, the MCPs are often able to maintain or improve upon the positive outcomes. While the QIPs demonstrated some positive outcomes related to the timeliness of care provided to MCMC members, the MCPs continued to show many opportunities for improvement related to their approaches to improving timeliness of care for members.

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 partially compliant with most of the standards and had findings in multiple areas. MCPs generally had appropriate resources and written policies and procedures in place to support quality improvement programs.

Most weighted averages for MCMC 2014 performance measures fell between the MPLs and HPLs, with six measures having rates below the DHCS-established MPLs. The weighted average rates improved significantly from 2013 to 2014 for five measures, and seven measures had rates that were significantly worse in 2014 when compared to 2013. While some MCPs continue to show many opportunities for improving performance on measures, most MCPs made some improvements from 2013 to 2014.

As in previous years, most of the performance measures showing the greatest opportunity for improvement fell under the quality and access domains of care. MCMC's more robust monitoring processes and focus on rapid-cycle improvement strategies should increase the likelihood of the MCPs achieving statistically significant and sustained improvement over time on measures with below-average rates.

During the review period, HSAG assessed QIPs in all three domains of care for outcomes. As in previous years, results showed that, generally, once a QIP achieves statistically significant improvement, MCPs are often able to maintain or improve upon the positive outcomes. While the

QIPs demonstrated some positive outcomes related to the health care services provided to MCMC members, the MCPs continued to show many opportunities for improvement related to their approaches to improving the quality and timeliness of, and access to, care for MCMC members.

Recommendations

Based on its overall assessment of MCMC in the areas of quality and timeliness of, and access to, care, HSAG provided detailed recommendations, as applicable, 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. The MCPs' documentation of actions taken that address the 2012–13 external quality review recommendations are included in each MCP's 2013–14 evaluation report. DHCS's documentation of actions taken in response to the 2012–13 external quality review recommendations is included in Appendix D of this report.

APPENDIX A. INDIVIDUAL MANAGED CARE HEALTH PLAN PERFORMANCE MEASURE RESULTS

Full-Scope Managed Care Health Plans

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 specification changes impacting comparability. DHCS based the MPLs and HPLs on NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, a lower rate indicates better performance, and a higher rate indicates worse performance. For this measure only, the established MPL is based on the national Medicaid 75th percentile, and the established HPL is based on the national Medicaid 10th percentile.

The *All-Cause Readmissions* measure is a non-HEDIS measure used for the *ACR* collaborative QIP; therefore, no MPL or HPL is established for this measure. For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).

The following key provides definitions of symbols used in the tables on the following pages, which contain performance measure results for 2011–14. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

Symbol	Definition
1	DHCS-selected HEDIS performance measures developed by NCQA, with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
2	HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
3	2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
4	2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
5	2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
6	2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
7	Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.

Symbol	Definition
*	Member months are a member's "contribution" to the total yearly membership.
‡	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 the rate is not available.
↓	Statistically significant decline.
↔	No statistically significant change.
↑	Statistically significant improvement.
▲▼	Used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA	A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).
S	The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table A.1—Performance Measure Results
Alameda Alliance for Health—Alameda County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.66%	17.42%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	42.02	47.24	29.28	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	315.03	297.17	240.12	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	87.05%	84.40%	**83.78%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	**86.41%**	94.08%	93.43%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	84.78%	**81.92%**	84.34%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	35.61%	31.53%	38.09%	40.90%	↔
Cervical Cancer Screening	Q,A	—	—	—	59.85%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	**47.92%**	78.10%	79.08%	67.40%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**94.63%**	**92.32%**	**94.34%**	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**85.48%**	**83.91%**	**85.10%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**85.61%**	**85.06%**	**87.07%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**82.03%**	**84.64%**	**83.24%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	55.65%	59.85%	59.61%	57.66%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	**40.00%**	52.55%	48.91%	45.26%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.00%	83.21%	83.45%	81.75%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	40.00%	58.88%	51.58%	48.18%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	34.09%	43.55%	36.74%	29.20%	↓
Comprehensive Diabetes Care—LDL-C Screening	Q,A	74.26%	76.89%	77.62%	71.29%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	81.74%	82.97%	82.97%	80.05%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	49.91%	28.47%	37.47%	51.82%	▼
Controlling High Blood Pressure	Q	—	—	53.53%	**45.99%**	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	66.67%	76.40%	79.08%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**43.88%**	**41.69%**	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**24.23%**	**17.80%**	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	58.84%	61.07%	**57.18%**	**49.39%**	↓

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**64.65%**	88.56%	80.54%	**79.56%**	↔
Use of Imaging Studies for Low Back Pain	Q	84.26%	84.76%	87.07%	88.58%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	39.58%	55.23%	55.23%	59.61%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	80.09%	58.64%	64.72%	71.29%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	55.79%	41.61%	46.23%	61.31%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	68.75%	77.62%	71.53%	70.80%	↔

Table A.2—Performance Measure Results
Anthem Blue Cross Partnership Plan—Alameda County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.67%	18.16%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	55.63	68.25	67.55	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	215.86	154.77	212.17	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**79.35%**	**77.02%**	**81.73%**	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**72.88%**	**73.14%**	**80.81%**	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	34.31%	39.13%	42.36%	33.83%	↔
Cervical Cancer Screening	Q,A	—	—	—	**49.18%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	66.91%	70.56%	71.29%	71.30%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**93.51%**	**84.39%**	**85.16%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**82.89%**	**67.77%**	**77.82%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**84.12%**	**79.12%**	**78.58%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**79.44%**	**77.65%**	**75.18%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	**50.61%**	**47.45%**	**35.92%**	**38.41%**	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	**27.98%**	**35.28%**	**34.22%**	**35.10%**	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	**72.75%**	**73.48%**	**63.83%**	**75.94%**	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	**37.71%**	**32.36%**	**30.58%**	**26.05%**	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	29.20%	**22.38%**	**18.45%**	**17.66%**	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	**68.37%**	**66.91%**	**55.83%**	**61.37%**	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	**68.86%**	**68.86%**	**71.36%**	**73.95%**	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	**53.53%**	**60.58%**	**63.35%**	**67.55%**	↔
Controlling High Blood Pressure	Q	—	—	**30.66%**	**34.15%**	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	64.96%	73.16%	73.04%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**42.61%**	**44.30%**	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**20.87%**	**21.94%**	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**51.09%**	**50.61%**	**36.74%**	**50.23%**	↑

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**65.94%**	**72.99%**	**75.18%**	**73.95%**	↔
Use of Imaging Studies for Low Back Pain	Q	86.88%	91.46%	90.20%	88.04%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	46.96%	44.04%	62.29%	46.17%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	55.23%	62.04%	61.07%	**47.33%**	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	28.47%	31.14%	37.47%	40.84%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	**62.04%**	73.71%	**57.32%**	**65.51%**	↑

Table A.3—Performance Measure Results
Anthem Blue Cross Partnership Plan—Contra Costa County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	18.62%	17.30%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	52.2	61.62	62.60	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	213.84	202.66	234.67	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**76.67%**	**77.90%**	**80.33%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**67.86%**	**71.53%**	**75.90%**	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	30.00%	NA	54.29%	42.42%	↔
Cervical Cancer Screening	Q,A	—	—	—	**53.94%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	68.61%	68.37%	76.16%	75.46%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**93.04%**	96.93%	**95.12%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**82.73%**	**85.01%**	86.44%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**80.01%**	**85.18%**	88.29%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**80.28%**	**82.76%**	**84.96%**	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	55.20%	**46.72%**	**50.99%**	**46.13%**	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	**26.40%**	**36.50%**	**38.61%**	**37.64%**	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	**69.60%**	**67.15%**	**69.31%**	**75.28%**	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	**35.20%**	**29.20%**	**39.60%**	**36.16%**	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	**26.40%**	**16.79%**	29.21%	29.52%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	**61.60%**	**57.66%**	**64.36%**	**67.16%**	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	**66.40%**	**64.96%**	**67.33%**	78.60%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	**58.40%**	**65.69%**	**52.97%**	**56.83%**	↔
Controlling High Blood Pressure	Q	—	—	**46.15%**	**43.88%**	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	65.02%	68.35%	65.30%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**40.34%**	**40.74%**	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**18.18%**	**21.60%**	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**43.55%**	**48.15%**	**44.64%**	**44.26%**	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**69.35%**	**76.30%**	**79.46%**	**72.95%**	↔
Use of Imaging Studies for Low Back Pain	Q	85.92%	92.59%	81.48%	S	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	49.15%	42.58%	57.66%	50.00%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	52.80%	53.77%	52.31%	55.09%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	35.28%	**25.55%**	36.74%	47.92%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	**63.26%**	67.45%	**63.93%**	75.83%	↑

Table A.4—Performance Measure Results
Anthem Blue Cross Partnership Plan—Fresno County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	13.83%	14.38%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	43.10	48.83	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	247.54	236.16	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	**80.77%**	**82.80%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	**81.48%**	**82.63%**	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	30.68%	—	29.65%	33.76%	↔
Cervical Cancer Screening	Q,A	—	—	—	**50.93%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	**60.34%**	—	70.80%	67.36%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	**94.35%**	**93.76%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	**82.85%**	**83.38%**	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	**80.34%**	**83.51%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	**76.54%**	**79.14%**	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	59.27%	—	58.74%	**52.44%**	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	**34.88%**	—	**38.35%**	44.89%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	79.76%	—	**77.18%**	79.33%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	**36.10%**	—	**41.99%**	**36.22%**	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	28.05%	—	32.77%	30.89%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	75.12%	—	71.84%	74.89%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	79.02%	—	77.43%	80.22%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	**54.39%**	—	50.24%	50.00%	↔
Controlling High Blood Pressure	Q	—	—	50.85%	53.32%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	70.80%	68.22%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**35.29%**	**33.16%**	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**14.10%**	**15.57%**	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**50.85%**	—	**54.74%**	**52.90%**	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**70.56%**	—	**79.56%**	**74.94%**	↔
Use of Imaging Studies for Low Back Pain	Q	80.58%	—	84.06%	82.85%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	47.20%	—	58.88%	54.29%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	53.04%	—	63.02%	59.86%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	36.25%	—	46.23%	49.65%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.72%	—	67.88%	79.63%	↑

Table A.5—Performance Measure Results
Anthem Blue Cross Partnership Plan—Kings County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	16.58%	8.43%	▲
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	68.85	68.06	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	368.80	320.37	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	85.71%	**81.64%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	84.56%	**77.36%**	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	28.57%	32.69%	↔
Cervical Cancer Screening	Q,A	—	—	—	**56.05%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	66.77%	68.51%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	**95.06%**	**94.74%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	**86.53%**	**83.25%**	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	**84.78%**	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	**84.64%**	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	58.44%	54.39%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	**38.31%**	**40.35%**	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	**75.00%**	**72.51%**	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	**38.64%**	**25.73%**	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	**25.97%**	**19.59%**	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	73.05%	**68.42%**	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	**73.38%**	77.19%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	**55.19%**	**64.91%**	▼
Controlling High Blood Pressure	Q	—	—	**43.55%**	**43.30%**	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	56.12%	69.66%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	NA	**40.22%**	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	NA	**16.30%**	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	**54.37%**	**45.70%**	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	86.11%	80.08%	↔
Use of Imaging Studies for Low Back Pain	Q	—	—	76.03%	84.30%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	46.47%	40.74%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	44.04%	**43.29%**	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	**31.39%**	38.66%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	**57.66%**	**65.05%**	↑

Table A.6—Performance Measure Results
Anthem Blue Cross Partnership Plan—Madera County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	10.87%	8.63%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	59.71	58.44	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	313.66	293.80	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	**76.60%**	**84.36%**	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	**78.26%**	**78.64%**	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	**6.25%**	20.00%	↔
Cervical Cancer Screening	Q,A	—	—	—	60.19%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	76.40%	**63.78%**	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	97.83%	98.47%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	88.53%	90.94%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	90.80%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	88.72%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	66.81%	61.09%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	55.02%	54.91%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	84.72%	84.36%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	51.97%	43.27%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	31.44%	29.09%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	72.93%	**69.09%**	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	79.04%	80.73%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	36.24%	47.64%	▼
Controlling High Blood Pressure	Q	—	—	53.36%	53.36%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	67.29%	72.62%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	NA	**29.66%**	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	NA	**16.95%**	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	**51.57%**	59.89%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	**76.10%**	**77.47%**	↔
Use of Imaging Studies for Low Back Pain	Q	—	—	**70.10%**	83.54%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	77.62%	56.94%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	70.07%	61.81%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	48.66%	52.55%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	80.29%	86.81%	↑

Table A.7—Performance Measure Results
Anthem Blue Cross Partnership Plan—Sacramento County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	12.63%	11.83%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	41.3	53.18	53.51	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	210.8	210.46	216.69	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**61.68%**	**65.15%**	**80.33%**	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	**86.11%**	87.80%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**61.75%**	**67.21%**	**80.50%**	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	23.10%	24.14%	31.29%	27.54%	↔
Cervical Cancer Screening	Q,A	—	—	—	**50.70%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	**57.66%**	**57.42%**	**62.77%**	**58.80%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**94.51%**	**93.16%**	**94.03%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**81.91%**	**80.19%**	**81.58%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**81.22%**	**81.14%**	**80.92%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**80.23%**	**80.56%**	**78.14%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	54.99%	56.20%	57.04%	**50.11%**	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	**28.22%**	**32.36%**	**28.16%**	**37.75%**	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	76.40%	**76.16%**	**75.24%**	**75.28%**	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	43.55%	49.15%	46.12%	40.18%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	29.68%	**25.79%**	**27.18%**	29.36%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	**64.48%**	**62.04%**	**67.23%**	**64.68%**	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	**72.02%**	**71.53%**	**71.60%**	79.47%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	47.93%	42.58%	47.09%	47.68%	↔
Controlling High Blood Pressure	Q	—	—	**47.45%**	**48.11%**	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	51.58%	61.80%	62.62%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**44.31%**	49.21%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**21.54%**	30.61%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**49.88%**	**54.26%**	**47.92%**	**49.88%**	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**70.32%**	**76.89%**	**78.73%**	**72.39%**	↓
Use of Imaging Studies for Low Back Pain	Q	83.69%	84.94%	84.34%	83.20%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	49.88%	63.02%	65.45%	61.11%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	59.61%	71.29%	69.34%	63.43%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	27.74%	39.42%	44.53%	47.45%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.72%	**64.33%**	67.37%	70.83%	↔

Table A.8—Performance Measure Results
Anthem Blue Cross Partnership Plan—San Francisco County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.19%	16.67%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	38.76	52.12	58.29	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	250.78	275.35	293.45	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**80.10%**	**82.57%**	**84.48%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**79.10%**	**81.99%**	84.19%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	50.00%	50.53%	53.25%	53.49%	↔
Cervical Cancer Screening	Q,A	—	—	—	**54.80%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	79.08%	72.41%	74.68%	74.70%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	95.41%	96.11%	96.63%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	90.78%	86.94%	89.05%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	91.67%	90.85%	89.23%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	89.56%	89.58%	88.40%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	75.37%	62.33%	61.80%	56.44%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	46.31%	51.63%	45.26%	49.78%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.24%	83.72%	86.13%	82.00%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	55.67%	53.49%	52.55%	44.44%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	35.96%	37.67%	39.17%	32.00%	↓
Comprehensive Diabetes Care—LDL-C Screening	Q,A	75.37%	**69.77%**	75.91%	**70.44%**	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	81.77%	80.00%	85.89%	82.67%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	32.51%	33.95%	36.01%	47.56%	▼
Controlling High Blood Pressure	Q	—	—	51.82%	**48.45%**	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	69.42%	68.02%	76.52%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**38.20%**	**42.61%**	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**17.98%**	25.22%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**55.50%**	64.02%	64.85%	**56.55%**	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	87.96%	85.71%	88.48%	**77.38%**	↓
Use of Imaging Studies for Low Back Pain	Q	85.37%	80.39%	86.73%	89.11%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	53.53%	73.24%	60.06%	78.47%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	70.80%	79.32%	72.99%	75.00%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	56.20%	71.78%	65.52%	68.06%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	76.40%	80.00%	79.26%	80.55%	↔

Table A.9—Performance Measure Results
Anthem Blue Cross Partnership Plan—Santa Clara County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	13.74%	13.75%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	37.89	41.51	47.16	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	232.42	254.81	257.20	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	84.95%	86.63%	87.64%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	84.21%	86.61%	85.77%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	28.83%	20.00%	27.20%	28.24%	↔
Cervical Cancer Screening	Q,A	—	—	—	62.56%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	70.56%	66.91%	74.94%	67.82%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	95.63%	95.81%	**95.43%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**86.67%**	87.39%	87.49%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**87.63%**	88.05%	89.72%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**86.34%**	87.62%	**85.64%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	72.51%	65.69%	58.50%	**44.15%**	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	53.77%	64.48%	49.76%	45.25%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	87.35%	85.89%	79.85%	83.00%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	60.10%	61.31%	53.88%	45.03%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	46.72%	47.20%	35.44%	40.40%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	84.67%	82.73%	76.94%	80.35%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	82.97%	79.56%	80.10%	80.13%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	31.87%	29.44%	39.08%	43.27%	↔
Controlling High Blood Pressure	Q	—	—	**46.72%**	**40.93%**	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	60.10%	68.86%	72.45%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**43.37%**	**43.67%**	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	28.11%	24.90%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	65.69%	60.64%	**56.20%**	60.65%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.45%	**79.52%**	**76.71%**	80.09%	↔
Use of Imaging Studies for Low Back Pain	Q	83.92%	82.43%	83.67%	80.35%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	65.69%	53.28%	55.23%	48.15%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	63.50%	70.56%	65.94%	**46.99%**	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	35.52%	38.44%	50.36%	**34.49%**	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	70.07%	76.72%	76.72%	74.45%	↔

Table A.10—Performance Measure Results
Anthem Blue Cross Partnership Plan—Tulare County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	11.70%	10.59%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	25.62	42.20	42.71	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	194.99	293.82	325.32	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**70.48%**	**78.55%**	85.06%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**69.03%**	**81.57%**	84.53%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	**15.85%**	20.19%	19.52%	23.42%	↔
Cervical Cancer Screening	Q,A	—	—	—	63.43%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	69.10%	64.96%	71.78%	72.22%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**92.51%**	**92.47%**	97.75%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**71.01%**	**82.72%**	90.35%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**81.80%**	**79.60%**	88.21%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**82.21%**	**82.20%**	87.52%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	64.96%	68.13%	68.45%	54.97%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	**29.20%**	**33.09%**	**35.68%**	47.02%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	77.13%	**77.13%**	**78.40%**	83.00%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	42.09%	45.26%	48.54%	42.60%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	31.87%	33.09%	32.52%	29.36%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	69.83%	**68.61%**	**69.66%**	73.07%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	76.89%	77.62%	81.55%	81.46%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	49.64%	45.74%	43.69%	46.36%	↔
Controlling High Blood Pressure	Q	—	—	53.28%	52.99%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	57.91%	70.97%	78.70%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**38.07%**	**43.12%**	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**18.88%**	**21.05%**	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	63.99%	**53.13%**	**55.96%**	58.24%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	82.73%	83.07%	**76.16%**	82.37%	↑
Use of Imaging Studies for Low Back Pain	Q	79.56%	80.85%	81.07%	85.90%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	32.60%	83.94%	81.51%	65.28%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	48.91%	68.13%	64.23%	57.18%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	30.17%	50.36%	47.93%	47.92%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.24%	71.95%	**64.91%**	71.93%	↑

Table A.11—Performance Measure Results
CalOptima—Orange County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	16.69%	15.22%	▲
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	36.79	36.08	34.90	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	351.89	330.09	271.66	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	90.25%	90.75%	90.55%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	90.38%	93.54%	89.69%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	89.29%	90.65%	89.62%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	21.77%	20.73%	21.81%	20.65%	↔
Cervical Cancer Screening	Q,A	—	—	—	71.63%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	84.52%	81.30%	84.25%	79.40%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	97.67%	97.34%	97.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	92.55%	91.12%	91.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	92.05%	91.64%	92.30%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	90.37%	90.41%	89.07%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	70.37%	73.76%	73.95%	69.30%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	61.66%	69.25%	66.05%	67.91%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	86.06%	86.45%	82.33%	85.12%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	61.22%	58.71%	56.98%	59.07%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	48.15%	50.75%	40.23%	49.77%	↑
Comprehensive Diabetes Care—LDL-C Screening	Q,A	84.53%	85.59%	80.70%	84.88%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	83.22%	85.38%	83.02%	85.81%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	28.54%	30.97%	37.21%	32.33%	↔
Controlling High Blood Pressure	Q	—	—	64.64%	67.25%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	69.21%	80.86%	84.15%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	48.71%	50.10%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	25.60%	28.33%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	72.37%	69.38%	63.66%	58.96%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	85.79%	84.82%	**78.42%**	85.07%	↑
Use of Imaging Studies for Low Back Pain	Q	77.18%	79.00%	78.34%	75.25%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	72.35%	76.92%	81.39%	75.68%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	76.30%	81.43%	82.78%	84.19%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	68.15%	71.62%	75.56%	72.64%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	82.52%	82.54%	86.69%	83.94%	↔

Table A.12—Performance Measure Results
CalViva Health—Fresno County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	10.64%	13.10%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	45.57	50.13	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	448.77	469.48	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	**82.27%**	84.64%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	**86.60%**	**80.77%**	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	**83.02%**	84.96%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	38.41%	38.66%	↔
Cervical Cancer Screening	Q,A	—	—	—	64.34%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	76.89%	71.80%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	97.82%	96.60%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	91.50%	91.08%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	91.74%	91.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	90.68%	87.51%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	**48.66%**	54.26%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	48.91%	48.42%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	82.97%	79.81%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	43.80%	**38.20%**	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	36.74%	32.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	76.64%	72.99%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	75.67%	76.89%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	47.45%	**54.74%**	▼
Controlling High Blood Pressure	Q	—	—	58.88%	53.12%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	76.89%	72.46%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	70.53%	**44.11%**	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	43.01%	24.31%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	63.75%	61.20%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	90.02%	88.02%	↔
Use of Imaging Studies for Low Back Pain	Q	—	—	82.11%	79.90%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	69.10%	64.96%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	71.29%	74.94%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	44.53%	52.55%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	81.51%	82.69%	↔

Table A.13—Performance Measure Results
CalViva Health—Kings County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	10.31%	7.92%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	60.31	62.09	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	452.56	430.69	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	**80.23%**	87.21%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	**78.03%**	84.25%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	32.14%	**17.24%**	↔
Cervical Cancer Screening	Q,A	—	—	—	**57.18%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	69.83%	70.06%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	96.98%	**94.68%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	89.73%	**83.58%**	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	**87.06%**	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	**84.62%**	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	**50.36%**	**45.50%**	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	**42.82%**	48.42%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	80.54%	**78.59%**	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	**41.85%**	**39.66%**	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	**27.98%**	32.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	74.94%	74.21%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	78.35%	78.10%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	**50.85%**	52.07%	↔
Controlling High Blood Pressure	Q	—	—	55.23%	**41.03%**	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	73.59%	73.20%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	NA	48.59%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	NA	30.51%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	**57.46%**	**52.84%**	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	89.93%	82.67%	↓
Use of Imaging Studies for Low Back Pain	Q	—	—	75.50%	80.23%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	48.42%	**37.47%**	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	53.28%	**45.99%**	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	41.36%	36.98%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	67.40%	**59.29%**	↓

Table A.14—Performance Measure Results
CalViva Health—Madera County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	10.81%	13.40%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	50.89	52.05	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	444.01	482.26	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	**80.80%**	**83.06%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	**81.88%**	85.94%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	25.61%	**16.67%**	↔
Cervical Cancer Screening	Q,A	—	—	—	64.44%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	71.29%	66.96%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	98.53%	98.08%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	91.75%	93.49%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	92.88%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	90.68%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	59.37%	64.96%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	55.72%	60.34%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	85.89%	88.32%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	46.47%	43.07%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	33.09%	34.31%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	**70.32%**	74.45%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	81.27%	82.00%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	43.31%	49.39%	↔
Controlling High Blood Pressure	Q	—	—	56.69%	52.10%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	65.66%	69.68%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	NA	**42.78%**	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	NA	24.23%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	65.90%	**50.27%**	↓

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	93.35%	80.05%	↓
Use of Imaging Studies for Low Back Pain	Q	—	—	77.17%	**70.68%**	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	62.29%	59.28%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	73.72%	68.81%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	64.72%	60.82%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	84.43%	87.34%	↔

Table A.15—Performance Measure Results
Care1st Partner Plan—San Diego County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	15.64%	15.57%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	48.06	50.84	51.00	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	239.46	291.33	279.31	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	89.19%	**81.79%**	**83.72%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	86.76%	**80.19%**	83.96%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	28.00%	**15.38%**	20.83%	27.41%	↔
Cervical Cancer Screening	Q,A	—	—	—	**43.31%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	79.81%	73.24%	72.75%	**65.45%**	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**90.56%**	**93.54%**	**89.27%**	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**78.47%**	**82.76%**	**80.91%**	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**81.48%**	**82.67%**	**80.88%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**77.75%**	**81.15%**	**78.71%**	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	66.06%	73.90%	58.39%	**46.72%**	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	41.82%	47.39%	**40.39%**	**37.71%**	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	83.64%	88.76%	84.91%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	52.73%	49.00%	51.82%	42.58%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	46.06%	38.15%	37.23%	32.36%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	80.61%	81.53%	78.59%	72.99%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	87.27%	88.35%	85.40%	82.24%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	30.91%	36.95%	42.09%	51.82%	▼
Controlling High Blood Pressure	Q	—	—	51.71%	**42.82%**	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	62.13%	70.26%	67.88%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**40.59%**	54.55%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	24.75%	37.01%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	60.45%	67.06%	59.18%	60.58%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**80.00%**	85.00%	81.12%	81.02%	↔
Use of Imaging Studies for Low Back Pain	Q	**61.02%**	82.72%	**70.00%**	72.11%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	57.18%	65.94%	74.45%	54.99%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	63.26%	68.37%	72.26%	62.29%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	36.25%	46.72%	51.58%	37.96%	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	76.79%	73.44%	67.07%	**67.34%**	↔

Table A.16—Performance Measure Results
CenCal Health—San Luis Obispo County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	13.49%	12.28%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	65.82	63.56	58.78	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	343.58	346.43	334.76	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**82.95%**	**81.02%**	**80.16%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**82.35%**	84.20%	84.92%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	34.44%	33.33%	**14.46%**	**17.24%**	↔
Cervical Cancer Screening	Q,A	—	—	—	62.77%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	76.32%	76.39%	78.03%	77.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.17%	**95.31%**	96.78%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	87.31%	**86.21%**	89.60%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	88.32%	87.64%	90.47%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**86.08%**	86.69%	86.83%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	66.91%	67.64%	70.56%	65.94%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	60.83%	61.56%	58.39%	59.12%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	**73.72%**	81.02%	82.00%	84.18%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	51.34%	59.37%	61.31%	58.15%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	38.69%	41.36%	42.58%	40.15%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	75.43%	78.59%	79.56%	79.08%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	79.32%	84.67%	82.73%	85.40%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	41.12%	32.60%	31.14%	30.90%	↔
Controlling High Blood Pressure	Q	—	—	63.02%	54.43%	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	60.10%	71.65%	65.79%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**42.34%**	45.28%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	26.28%	26.77%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	70.42%	70.11%	71.04%	70.47%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	84.51%	82.76%	87.43%	87.13%	↔
Use of Imaging Studies for Low Back Pain	Q	78.38%	77.86%	75.69%	80.89%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	46.96%	62.29%	64.23%	77.13%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	57.91%	59.61%	61.31%	60.10%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	34.79%	47.69%	50.36%	51.82%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	**63.66%**	69.79%	67.97%	72.95%	↔

Table A.17—Performance Measure Results
CenCal Health—Santa Barbara County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	11.13%	13.15%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	48.37	52.16	51.43	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	346.64	335.52	301.90	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	86.89%	84.72%	85.79%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	**86.11%**	**84.85%**	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	87.25%	85.46%	86.74%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	31.61%	29.55%	19.13%	22.62%	↔
Cervical Cancer Screening	Q,A	—	—	—	74.45%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	82.31%	85.20%	85.84%	83.56%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	97.31%	97.84%	98.49%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	90.42%	91.16%	93.58%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	89.69%	90.88%	92.88%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	87.69%	89.29%	90.59%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	69.59%	69.10%	74.21%	72.02%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	70.32%	71.29%	70.56%	68.61%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	81.75%	92.21%	83.94%	86.37%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	61.56%	69.34%	59.61%	59.37%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	45.74%	50.12%	38.93%	40.39%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	76.89%	85.16%	80.54%	80.05%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	79.56%	87.35%	82.48%	84.91%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	28.95%	22.63%	33.58%	31.87%	↔
Controlling High Blood Pressure	Q	—	—	60.58%	60.25%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	70.07%	78.74%	80.90%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	47.38%	50.28%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	27.67%	26.70%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	77.57%	76.35%	73.44%	76.83%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.49%	80.74%	81.64%	85.98%	↔
Use of Imaging Studies for Low Back Pain	Q	80.67%	80.46%	80.57%	81.72%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	59.12%	66.42%	70.56%	74.21%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	72.51%	67.88%	72.75%	72.99%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	39.17%	44.77%	51.34%	57.66%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	74.39%	76.01%	79.34%	80.65%	↔

Table A.18—Performance Measure Results
Central California Alliance for Health—Merced County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	12.73%	12.78%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	49.09	53.69	52.70	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	320.62	324.06	321.41	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	86.41%	87.14%	86.87%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	**83.33%**	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	87.31%	86.97%	86.43%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	**15.09%**	**11.61%**	**16.23%**	18.62%	↔
Cervical Cancer Screening	Q,A	—	—	—	65.63%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	**55.23%**	64.72%	64.74%	68.68%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.92%	97.42%	97.63%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	91.25%	90.39%	91.65%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	89.54%	89.82%	90.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	87.63%	90.19%	88.46%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	67.15%	64.48%	64.96%	62.53%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	41.61%	56.20%	54.74%	53.53%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	86.13%	87.83%	84.91%	83.94%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	46.72%	51.34%	46.72%	44.28%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	36.01%	37.96%	33.09%	32.85%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	80.05%	80.29%	80.54%	78.59%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	86.37%	82.48%	84.91%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	44.04%	37.23%	45.99%	45.74%	↔
Controlling High Blood Pressure	Q	—	—	52.80%	53.66%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	50.12%	55.96%	64.86%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	48.30%	54.14%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	26.16%	29.04%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	63.02%	59.61%	58.79%	60.35%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	88.32%	85.40%	83.92%	82.79%	↔
Use of Imaging Studies for Low Back Pain	Q	79.87%	84.15%	79.33%	82.49%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	46.72%	58.88%	77.62%	82.24%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	62.29%	64.23%	66.91%	68.13%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	40.39%	44.28%	44.77%	43.07%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.97%	72.51%	74.33%	76.32%	↔

Table A.19—Performance Measure Results
Central California Alliance for Health—Monterey/Santa Cruz Counties

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	12.06%	11.58%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	51.95	52.10	46.64	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	320.58	318.74	303.75	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	88.31%	85.86%	87.34%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	87.93%	89.47%	87.76%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	88.95%	85.58%	87.02%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	26.36%	27.95%	22.27%	28.07%	↔
Cervical Cancer Screening	Q,A	—	—	—	72.22%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	82.73%	84.18%	83.84%	82.48%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	97.42%	98.49%	98.31%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	91.05%	91.29%	92.11%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	89.57%	90.89%	93.18%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	88.93%	91.00%	90.94%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	71.78%	76.64%	71.05%	75.18%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	65.94%	67.40%	63.02%	56.45%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	89.05%	91.97%	87.35%	86.86%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	56.45%	61.80%	51.09%	51.82%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	45.74%	47.20%	39.66%	35.77%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	84.43%	84.91%	78.83%	79.81%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	82.48%	79.81%	79.32%	79.32%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	33.33%	28.22%	36.98%	38.20%	↔
Controlling High Blood Pressure	Q	—	—	55.96%	59.46%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	63.99%	77.60%	80.29%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	49.96%	52.98%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**24.42%**	30.21%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	75.43%	77.62%	70.27%	69.83%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	93.43%	86.13%	81.76%	93.10%	↑
Use of Imaging Studies for Low Back Pain	Q	86.06%	85.12%	88.00%	85.20%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	69.83%	79.08%	81.89%	81.02%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	72.26%	80.29%	81.63%	78.59%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	61.31%	61.31%	66.58%	65.21%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	83.45%	83.21%	82.08%	80.29%	↔

Table A.20—Performance Measure Results
Community Health Group Partnership Plan—San Diego County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.37%	13.28%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	32.73	37.42	36.42	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	329	310.89	293.39	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	87.07%	84.99%	87.41%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	91.23%	95.71%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	85.01%	85.04%	88.16%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	**17.31%**	**14.08%**	32.02%	39.69%	↑
Cervical Cancer Screening	Q,A	—	—	—	65.21%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	78.10%	73.97%	73.97%	70.07%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.21%	97.32%	95.95%	↓
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	90.27%	89.85%	89.92%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	89.61%	89.90%	89.41%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	88.45%	88.64%	**85.47%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	65.69%	57.18%	64.72%	**45.99%**	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	61.07%	53.28%	55.47%	55.47%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	88.32%	87.35%	90.02%	86.13%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	52.31%	47.69%	56.45%	45.01%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	40.63%	35.04%	39.66%	39.66%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	84.67%	82.24%	83.70%	81.75%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	77.21%	79.08%	83.21%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	37.71%	43.80%	34.31%	40.88%	↔
Controlling High Blood Pressure	Q	—	—	52.07%	52.07%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	73.48%	79.32%	76.40%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**35.41%**	47.09%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**18.66%**	27.95%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**57.18%**	60.10%	**55.23%**	57.91%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**79.08%**	**77.86%**	82.24%	80.29%	↔
Use of Imaging Studies for Low Back Pain	Q	77.75%	75.03%	79.24%	77.32%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	63.26%	73.48%	78.10%	87.59%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	69.83%	71.53%	71.29%	75.43%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	40.39%	55.96%	63.99%	70.32%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	74.95%	77.13%	77.86%	78.10%	↔

Table A.21—Performance Measure Results
Contra Costa Health Plan—Contra Costa County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	16.99%	12.95%	▲
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	59.47	60.94	53.25	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	274.88	217.23	246.81	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	85.62%	83.77%	86.52%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	**85.71%**	95.45%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**80.95%**	83.68%	85.11%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	29.56%	26.52%	43.27%	44.09%	↔
Cervical Cancer Screening	Q,A	—	—	—	**54.99%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	87.16%	85.40%	84.47%	74.70%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**93.97%**	**86.74%**	**94.62%**	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**84.54%**	**76.18%**	**86.07%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**84.07%**	**77.96%**	**86.71%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**83.25%**	**74.86%**	**83.44%**	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	55.11%	54.99%	59.37%	61.31%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	49.09%	52.80%	51.09%	51.34%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	86.86%	84.91%	85.40%	84.43%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	56.57%	53.04%	49.88%	48.18%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	40.69%	36.25%	41.61%	42.34%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	77.74%	75.43%	82.00%	75.67%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	89.23%	87.35%	82.00%	83.94%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	33.94%	36.98%	40.39%	41.61%	↔
Controlling High Blood Pressure	Q	—	—	51.34%	53.28%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	59.85%	71.61%	73.24%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	56.90%	**43.46%**	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	33.95%	22.79%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	67.40%	64.96%	62.53%	60.34%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	81.75%	83.21%	86.86%	83.45%	↔
Use of Imaging Studies for Low Back Pain	Q	88.64%	88.58%	92.06%	87.85%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	61.07%	59.37%	56.20%	62.29%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	58.88%	55.72%	55.96%	59.37%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	46.47%	46.47%	46.23%	50.85%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	78.82%	77.86%	73.31%	74.45%	↔

Table A.22—Performance Measure Results
Gold Coast Health Plan—Ventura County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	19.17%	13.08%	▲
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	49.21	38.12	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	317.16	205.78	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	86.73%	88.47%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	88.46%	93.33%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	86.28%	89.51%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	**13.87%**	18.24%	↔
Cervical Cancer Screening	Q,A	—	—	—	60.58%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	80.05%	75.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	**82.51%**	97.37%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	**63.09%**	**86.27%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	**82.26%**	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	**79.18%**	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	62.29%	61.31%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	**42.58%**	45.74%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	81.75%	85.16%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	**37.96%**	45.50%	↑
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	33.58%	28.47%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	78.83%	79.56%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	79.81%	78.10%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	**56.20%**	45.50%	▲
Controlling High Blood Pressure	Q	—	—	61.56%	54.01%	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	65.21%	60.34%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	NA	48.92%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	NA	28.03%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	63.99%	59.37%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	80.78%	83.94%	↔
Use of Imaging Studies for Low Back Pain	Q	—	—	76.95%	77.07%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	42.09%	43.80%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	**42.09%**	**43.31%**	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	**30.41%**	**28.71%**	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	**61.80%**	**64.23%**	↔

Table A.23—Performance Measure Results
Health Net Community Solutions, Inc.—Kern County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	10.40%	11.50%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	47.52	53.28	54.16	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	269.41	200.09	350.94	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**77.67%**	**75.85%**	**82.19%**	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	**83.33%**	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**79.57%**	**76.59%**	**81.82%**	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	**18.18%**	**17.23%**	26.00%	23.14%	↔
Cervical Cancer Screening	Q,A	—	—	—	**49.64%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	70.44%	71.35%	68.71%	**65.28%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**93.78%**	**89.78%**	**92.95%**	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**80.79%**	**70.48%**	**79.16%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**78.17%**	**68.16%**	**67.96%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**81.18%**	**76.57%**	**67.50%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	58.41%	65.82%	**50.12%**	**50.36%**	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	50.24%	54.04%	**44.28%**	**42.34%**	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	79.09%	78.52%	**73.24%**	**76.89%**	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	40.63%	40.88%	**38.20%**	**33.33%**	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	36.54%	35.57%	38.93%	35.52%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	76.44%	73.21%	72.75%	74.45%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	82.69%	83.14%	80.78%	79.32%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	48.80%	50.58%	**52.80%**	**60.10%**	▼
Controlling High Blood Pressure	Q	—	—	51.34%	**47.20%**	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	60.58%	71.90%	73.39%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	69.12%	55.20%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	51.47%	35.29%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	62.41%	62.41%	**53.09%**	**54.15%**	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	86.29%	89.47%	**78.87%**	**71.71%**	↓
Use of Imaging Studies for Low Back Pain	Q	73.50%	75.26%	73.53%	74.70%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	53.16%	55.28%	72.02%	78.65%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	69.66%	71.24%	81.02%	86.98%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	41.75%	51.24%	63.99%	77.86%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	72.02%	69.21%	65.54%	71.54%	↔

Table A.24—Performance Measure Results
Health Net Community Solutions, Inc.—Los Angeles County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	11.93%	11.64%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	33.03	36.51	35.29	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	241.22	251.36	274.97	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**74.03%**	**76.09%**	**80.35%**	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	**76.99%**	**85.92%**	**86.38%**	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**74.07%**	**76.27%**	**80.78%**	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	20.18%	21.40%	40.16%	27.72%	↓
Cervical Cancer Screening	Q,A	—	—	—	61.80%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	77.10%	87.62%	81.63%	76.15%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.13%	**94.29%**	**94.47%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	88.17%	**81.11%**	**81.18%**	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	87.98%	**83.12%**	**81.99%**	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**85.90%**	**82.82%**	**77.41%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	63.89%	67.53%	**50.12%**	59.61%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	55.32%	58.82%	47.69%	50.36%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.03%	83.53%	**78.10%**	79.81%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	46.30%	48.47%	**39.90%**	45.26%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	37.27%	37.41%	35.52%	37.23%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	80.79%	76.47%	75.43%	77.62%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	86.57%	82.35%	82.97%	81.27%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	40.74%	39.76%	48.42%	48.66%	↔
Controlling High Blood Pressure	Q	—	—	57.91%	56.33%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	65.02%	73.67%	78.66%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	72.65%	53.36%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	49.52%	33.05%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**58.21%**	**52.34%**	**48.05%**	**45.01%**	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	86.57%	83.64%	**73.41%**	**68.37%**	↔
Use of Imaging Studies for Low Back Pain	Q	80.02%	81.09%	78.01%	76.76%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	63.61%	71.53%	75.78%	70.35%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	71.33%	79.86%	80.73%	75.47%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	53.73%	63.66%	66.41%	67.65%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	79.10%	83.10%	77.08%	69.26%	↓

Table A.25—Performance Measure Results
Health Net Community Solutions, Inc.—Sacramento County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	12.15%	12.69%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	38.1	45.02	44.04	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	241	300.55	305.99	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**59.33%**	**67.16%**	**72.60%**	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	**82.46%**	**84.75%**	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**55.59%**	**67.40%**	**70.56%**	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	28.48%	20.21%	51.66%	27.62%	↓
Cervical Cancer Screening	Q,A	—	—	—	**48.91%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	67.33%	69.55%	66.67%	**59.57%**	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	95.41%	**92.53%**	**92.57%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**84.73%**	**80.19%**	**81.06%**	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**84.22%**	**80.69%**	**79.43%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**83.57%**	**81.64%**	**75.02%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	59.55%	62.91%	**48.91%**	**45.99%**	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	45.62%	48.36%	**40.63%**	**37.96%**	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	83.82%	83.57%	**77.86%**	**77.62%**	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	49.21%	52.82%	43.55%	48.18%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	37.75%	33.57%	35.77%	33.33%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	76.40%	73.94%	**67.40%**	**67.64%**	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	81.57%	82.63%	83.45%	80.29%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	40.00%	35.92%	45.26%	46.23%	↔
Controlling High Blood Pressure	Q	—	—	54.50%	**45.72%**	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	54.61%	63.08%	62.76%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	78.74%	58.83%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	55.94%	40.03%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	60.57%	60.78%	**53.16%**	**49.02%**	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	87.89%	83.58%	81.77%	**77.07%**	↔
Use of Imaging Studies for Low Back Pain	Q	87.78%	87.52%	87.00%	85.49%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	67.88%	69.51%	77.32%	59.06%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	73.48%	77.58%	76.34%	72.95%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	41.61%	52.69%	57.07%	58.81%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	81.85%	78.20%	71.18%	67.54%	↔

Table A.26—Performance Measure Results
Health Net Community Solutions, Inc.—San Diego County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	15.96%	15.90%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	44.1	50.92	46.66	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	258.6	317.66	354.48	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**78.12%**	**83.68%**	89.08%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	100.00%	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**77.56%**	83.82%	88.33%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	**18.12%**	**18.46%**	44.85%	28.18%	↓
Cervical Cancer Screening	Q,A	—	—	—	**39.66%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	69.82%	77.30%	72.30%	67.46%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**94.01%**	**93.98%**	95.87%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**85.83%**	**85.27%**	87.67%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**85.38%**	**84.91%**	**86.20%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**82.99%**	**82.51%**	**82.09%**	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	53.78%	64.38%	**52.07%**	**46.23%**	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	47.43%	51.91%	45.99%	44.77%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.59%	84.48%	85.40%	**77.13%**	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	41.99%	48.35%	50.85%	**38.69%**	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	31.42%	35.62%	41.12%	30.90%	↓
Comprehensive Diabetes Care—LDL-C Screening	Q,A	73.41%	76.34%	79.08%	**70.32%**	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	82.18%	78.63%	82.24%	78.10%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	46.53%	41.48%	41.61%	**54.01%**	▼
Controlling High Blood Pressure	Q	—	—	55.23%	**44.72%**	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	65.29%	76.86%	66.23%	↓
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	75.28%	57.50%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	55.06%	40.00%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	62.47%	**54.77%**	**53.75%**	**41.11%**	↓

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	88.84%	83.38%	**76.67%**	**62.78%**	↓
Use of Imaging Studies for Low Back Pain	Q	74.07%	77.40%	76.04%	**64.79%**	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	51.34%	67.56%	72.99%	77.32%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	61.31%	67.78%	74.70%	74.59%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	43.07%	49.56%	67.15%	70.77%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	72.80%	70.00%	74.43%	76.64%	↔

Table A.27—Performance Measure Results
Health Net Community Solutions, Inc.—San Joaquin County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	18.60%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	53.47	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	266.70	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	**67.00%**	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	**65.45%**	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	NA	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	**20.92%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	**92.11%**	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	**76.97%**	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	NA	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	**34.96%**	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	**39.02%**	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	**73.17%**	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	**29.27%**	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	—	28.46%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	—	**60.16%**	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	81.30%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	**65.04%**	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	**30.86%**	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	NA	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	NA	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	**46.38%**	Not Comparable

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	**71.01%**	Not Comparable
Use of Imaging Studies for Low Back Pain	Q	—	—	—	NA	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	—	61.07%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	—	68.37%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	—	55.72%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	—	**59.12%**	Not Comparable

Table A.28—Performance Measure Results
Health Net Community Solutions, Inc.—Stanislaus County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	8.71%	10.97%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	49.38	55.13	62.40	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	349.91	369.94	392.65	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**75.91%**	83.73%	**83.17%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**79.78%**	84.46%	84.38%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	26.51%	29.55%	32.31%	22.19%	↓
Cervical Cancer Screening	Q,A	—	—	—	**48.18%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	67.80%	68.52%	71.67%	70.18%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	97.18%	97.04%	95.59%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	88.90%	87.15%	**85.89%**	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	87.88%	**85.24%**	**86.39%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**85.93%**	**86.00%**	**83.84%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	67.83%	67.30%	58.39%	58.64%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	48.70%	50.00%	**41.61%**	**41.36%**	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	82.03%	84.60%	88.32%	87.10%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	52.75%	53.08%	56.93%	51.82%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	37.39%	39.34%	34.55%	41.36%	↑
Comprehensive Diabetes Care—LDL-C Screening	Q,A	75.36%	76.07%	78.59%	77.62%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	82.03%	77.01%	78.59%	78.35%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	37.10%	36.49%	31.87%	37.23%	↔
Controlling High Blood Pressure	Q	—	—	56.20%	56.30%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	54.18%	65.77%	**56.65%**	↓
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	77.04%	57.78%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	52.55%	38.22%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	62.26%	60.10%	58.73%	**55.61%**	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	93.16%	91.52%	91.90%	83.29%	↓
Use of Imaging Studies for Low Back Pain	Q	77.57%	83.83%	83.22%	77.33%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	55.23%	58.68%	70.56%	66.83%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	63.26%	65.75%	65.69%	62.59%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	41.12%	40.18%	58.15%	66.08%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	75.60%	71.11%	70.47%	70.11%	↔

Table A.29—Performance Measure Results
Health Net Community Solutions, Inc.—Tulare County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	11.86%	11.74%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	39.3	41.73	42.27	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	386.74	467.09	505.10	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	83.59%	**83.50%**	84.77%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	91.43%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**79.73%**	84.60%	84.10%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	**17.54%**	22.85%	26.14%	24.05%	↔
Cervical Cancer Screening	Q,A	—	—	—	59.85%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	76.32%	78.93%	78.47%	75.69%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	97.32%	97.76%	97.60%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	92.25%	92.37%	91.99%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	92.76%	91.72%	91.23%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	91.48%	93.05%	89.42%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	71.33%	67.45%	**54.26%**	55.96%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	56.40%	56.84%	**41.85%**	50.12%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	86.49%	83.02%	86.62%	79.56%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	48.58%	47.88%	49.64%	45.26%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	32.23%	36.56%	36.50%	30.66%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	77.49%	76.18%	77.86%	**69.34%**	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	82.94%	82.78%	82.00%	79.56%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	41.71%	43.40%	43.55%	47.45%	↔
Controlling High Blood Pressure	Q	—	—	54.01%	**49.39%**	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	61.80%	78.32%	76.04%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	72.85%	52.92%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	47.68%	32.82%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	68.38%	67.93%	65.57%	57.98%	↓

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	93.21%	93.75%	90.16%	88.56%	↔
Use of Imaging Studies for Low Back Pain	Q	73.08%	82.72%	80.00%	83.22%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	73.40%	77.57%	76.64%	65.94%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	66.75%	66.36%	66.42%	65.69%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	49.17%	45.33%	49.15%	49.88%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	81.25%	77.32%	73.31%	80.18%	↑

Table A.30—Performance Measure Results
Health Plan of San Joaquin—San Joaquin County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	7.07%	11.06%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	38.16	46.68	45.89	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	283.73	274.87	249.11	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	85.56%	**83.69%**	**83.80%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	92.11%	94.12%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	85.05%	84.58%	84.29%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	27.13%	25.42%	29.24%	25.10%	↓
Cervical Cancer Screening	Q,A	—	—	—	61.12%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	74.45%	77.13%	76.40%	75.91%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.66%	97.49%	97.04%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	86.82%	87.59%	87.79%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**84.17%**	**85.71%**	**86.70%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**83.53%**	**84.94%**	**83.23%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	75.18%	77.62%	78.28%	65.69%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	52.31%	53.28%	45.62%	44.77%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	80.54%	81.51%	80.66%	**79.08%**	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	51.82%	55.96%	52.37%	51.82%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	31.39%	39.17%	35.22%	41.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	75.91%	78.59%	75.55%	75.18%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	76.16%	80.29%	82.12%	79.08%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	41.36%	36.74%	39.60%	40.15%	↔
Controlling High Blood Pressure	Q	—	—	66.42%	65.45%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	63.99%	67.15%	72.02%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**40.72%**	**43.45%**	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**21.82%**	23.04%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	65.21%	68.61%	64.48%	60.83%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	87.83%	88.08%	85.64%	82.24%	↔
Use of Imaging Studies for Low Back Pain	Q	82.45%	80.67%	81.80%	84.03%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	67.15%	73.48%	69.10%	70.32%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	69.59%	72.51%	72.75%	68.37%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	58.15%	65.69%	61.80%	55.96%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	81.27%	80.54%	76.16%	76.89%	↔

Table A.31—Performance Measure Results
Health Plan of San Joaquin—Stanislaus County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	—	13.11%	Not Comparable
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	—	56.07	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	—	272.99	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	—	84.64%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	—	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	—	87.39%	Not Comparable
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	—	**16.95%**	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	**41.08%**	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	—	**64.96%**	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	—	97.23%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	—	88.43%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	—	88.90%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	—	86.60%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	—	67.88%	Not Comparable
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	—	**37.23%**	Not Comparable
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	—	85.40%	Not Comparable
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	—	52.31%	Not Comparable
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	—	40.63%	Not Comparable
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	—	74.94%	Not Comparable
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	—	80.29%	Not Comparable
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	—	36.98%	Not Comparable
Controlling High Blood Pressure	Q	—	—	—	56.20%	Not Comparable
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	—	58.15%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	—	51.65%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	—	**21.98%**	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	—	**54.99%**	Not Comparable

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	—	**73.24%**	Not Comparable
Use of Imaging Studies for Low Back Pain	Q	—	—	—	76.51%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	—	54.01%	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	—	**41.85%**	Not Comparable
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	—	39.17%	Not Comparable
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	—	68.61%	Not Comparable

Table A.32—Performance Measure Results
Health Plan of San Mateo—San Mateo County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.52%	15.68%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	51.62	52.11	48.80	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	483.04	546.12	445.65	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	89.28%	89.51%	90.97%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	92.71%	94.95%	94.34%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	89.85%	90.57%	91.85%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	26.49%	34.06%	34.46%	37.13%	↔
Cervical Cancer Screening	Q,A	—	—	—	61.80%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	83.67%	80.29%	75.56%	82.11%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	95.89%	96.70%	97.13%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	88.34%	88.32%	90.40%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**87.75%**	89.36%	89.74%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**84.89%**	**85.61%**	**85.34%**	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	63.26%	66.18%	56.93%	**46.72%**	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	59.85%	61.07%	57.42%	60.83%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	86.62%	79.81%	83.70%	87.10%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	57.42%	55.72%	56.45%	54.01%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	46.96%	46.47%	46.96%	42.82%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	84.18%	82.00%	80.78%	80.78%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	86.62%	87.83%	82.97%	90.02%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	34.06%	37.96%	35.28%	38.69%	↔
Controlling High Blood Pressure	Q	—	—	51.34%	**29.93%**	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	68.49%	70.28%	78.45%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	48.51%	50.21%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	26.38%	27.69%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	61.84%	61.22%	59.18%	59.55%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.16%	81.89%	84.18%	82.66%	↔
Use of Imaging Studies for Low Back Pain	Q	84.62%	81.51%	80.07%	79.18%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	47.89%	66.67%	55.47%	67.32%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	75.43%	77.62%	70.05%	73.90%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	59.06%	63.99%	53.91%	63.66%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	75.44%	73.80%	77.13%	75.68%	↔

Table A.33—Performance Measure Results
Inland Empire Health Plan—Riverside/San Bernardino Counties

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.24%	14.73%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	49.54	51.67	48.50	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	326.35	347.94	288.05	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	84.22%	86.98%	86.33%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	89.45%	91.99%	90.80%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	83.53%	86.07%	85.42%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	23.88%	22.10%	22.53%	21.52%	↔
Cervical Cancer Screening	Q,A	—	—	—	70.47%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	69.44%	77.78%	78.24%	76.85%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.33%	96.75%	96.67%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	86.92%	86.91%	86.77%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**83.53%**	**83.18%**	**84.55%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**86.30%**	86.72%	**83.97%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	70.94%	75.76%	71.00%	62.88%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	42.31%	52.68%	59.40%	51.74%	↓
Comprehensive Diabetes Care—HbA1c Testing	Q,A	79.49%	82.98%	85.61%	84.69%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	45.94%	48.72%	50.81%	46.87%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	37.39%	38.69%	42.00%	40.60%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	79.70%	81.12%	83.53%	81.67%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	80.34%	83.68%	84.45%	82.13%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	43.80%	40.79%	36.19%	39.44%	↔
Controlling High Blood Pressure	Q	—	—	62.91%	67.56%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	63.66%	71.99%	70.60%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**44.25%**	52.09%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**21.96%**	29.48%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	62.94%	63.23%	59.63%	59.02%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	85.08%	86.42%	88.40%	86.42%	↔
Use of Imaging Studies for Low Back Pain	Q	78.42%	75.58%	77.47%	75.14%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	57.64%	77.55%	78.94%	79.86%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	65.97%	79.63%	74.54%	73.84%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	38.19%	52.78%	47.69%	53.01%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	74.31%	72.19%	75.69%	71.53%	↔

Table A.34—Performance Measure Results
Kaiser North—Sacramento County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	15.71%	16.07%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	53.84	57.00	48.07	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	413.25	410.03	370.32	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	93.04%	94.54%	95.24%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	92.53%	93.99%	95.09%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	54.76%	47.17%	54.55%	50.91%	↔
Cervical Cancer Screening	Q,A	—	—	—	89.97%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	80.24%	82.39%	83.88%	86.11%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	99.29%	98.38%	99.48%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	91.81%	90.32%	88.25%	↓
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	91.19%	91.82%	**84.70%**	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	92.95%	92.53%	**85.87%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	77.76%	81.69%	79.87%	80.00%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	67.52%	71.89%	66.16%	64.11%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	94.00%	95.57%	94.09%	94.47%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	63.11%	61.41%	59.37%	59.92%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	62.67%	65.59%	66.79%	68.77%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	92.06%	94.29%	92.70%	93.20%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	83.14%	89.44%	89.18%	93.44%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	21.54%	26.06%	27.30%	27.51%	↔
Controlling High Blood Pressure	Q	—	—	76.40%	82.00%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	—	80.91%	88.91%	86.14%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	56.75%	70.81%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	27.16%	42.79%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	71.71%	75.00%	75.55%	71.27%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	91.64%	93.33%	91.61%	92.82%	↔
Use of Imaging Studies for Low Back Pain	Q	87.46%	92.05%	89.48%	93.02%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	52.82%	73.52%	89.84%	92.61%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	60.33%	75.92%	89.41%	91.14%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	59.84%	75.56%	89.36%	91.11%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	69.03%	72.22%	77.88%	80.25%	↑

Table A.35—Performance Measure Results
Kaiser South—San Diego County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	17.51%	11.42%	▲
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	37.16	38.94	30.39	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	478.54	479.83	406.16	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	92.20%	93.22%	93.76%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	91.69%	92.74%	93.57%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	20.48%	38.30%	NA	NA	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	87.21%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	84.13%	87.02%	87.91%	88.11%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	99.48%	99.52%	99.51%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	94.39%	94.40%	93.60%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	94.52%	95.31%	89.97%	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	96.49%	96.97%	88.17%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	85.78%	87.95%	85.10%	88.86%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	77.12%	75.15%	76.07%	81.71%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	93.95%	96.23%	94.84%	96.56%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	65.52%	69.73%	69.91%	69.19%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	66.50%	69.43%	69.91%	69.19%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	93.63%	95.18%	92.84%	94.77%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	94.61%	95.18%	93.41%	94.91%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	21.24%	18.98%	18.34%	17.88%	↔
Controlling High Blood Pressure	Q	—	—	84.18%	86.37%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	88.30%	89.00%	85.54%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	61.18%	62.55%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	29.80%	32.73%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	68.47%	73.21%	70.20%	69.86%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	89.19%	94.74%	91.41%	91.39%	↔
Use of Imaging Studies for Low Back Pain	Q	84.18%	76.00%	83.03%	88.00%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	98.06%	97.80%	99.49%	99.57%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	51.17%	65.11%	91.46%	87.79%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	59.75%	76.31%	94.11%	91.18%	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	**64.58%**	68.55%	70.72%	73.70%	↑

Table A.36—Performance Measure Results
Kern Family Health Care—Kern County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	8.77%	14.94%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	46.64	51.02	50.26	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	282.07	255.50	263.68	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	83.81%	87.71%	88.95%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	90.74%	93.48%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	84.24%	87.62%	89.62%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	**18.27%**	**15.69%**	23.02%	26.35%	↔
Cervical Cancer Screening	Q,A	—	—	—	59.37%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	74.21%	68.61%	65.45%	66.67%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**94.23%**	**92.37%**	**93.24%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**84.12%**	**82.18%**	**84.37%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**79.80%**	**79.43%**	**81.39%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**81.78%**	**82.20%**	**80.60%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	64.96%	72.81%	75.36%	75.67%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	**32.36%**	52.55%	45.80%	45.01%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	79.81%	82.12%	80.29%	80.05%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	**36.50%**	45.26%	47.45%	44.53%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	29.20%	34.31%	33.58%	37.71%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	76.40%	79.38%	76.28%	77.86%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	74.45%	80.11%	77.55%	82.48%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	**54.26%**	45.99%	44.53%	46.96%	↔
Controlling High Blood Pressure	Q	—	—	64.96%	68.37%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	62.53%	75.67%	78.83%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**45.85%**	49.72%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**21.75%**	24.01%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	61.07%	60.34%	62.04%	61.07%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**78.35%**	81.27%	83.70%	81.02%	↔
Use of Imaging Studies for Low Back Pain	Q	**71.89%**	76.45%	74.07%	75.41%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	62.29%	61.80%	64.23%	67.15%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	46.96%	51.58%	66.42%	66.91%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	29.44%	38.44%	48.91%	56.20%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	70.32%	69.10%	67.64%	**66.18%**	↔

Table A.37—Performance Measure Results
L.A. Care Health Plan—Los Angeles County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	17.05%	15.50%	▲
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	31.02	32.23	35.61	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	191.44	185.93	310.27	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**73.44%**	**73.03%**	**78.93%**	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	**78.85%**	**78.09%**	**80.72%**	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**72.28%**	**72.87%**	**78.17%**	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	40.68%	32.31%	35.44%	27.88%	↓
Cervical Cancer Screening	Q,A	—	—	—	64.25%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	79.95%	81.45%	80.15%	77.78%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	95.16%	**91.06%**	**91.83%**	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	86.98%	**82.93%**	**82.82%**	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	88.20%	**87.15%**	**83.89%**	↓
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**86.43%**	**85.89%**	**79.45%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	58.45%	64.25%	65.94%	60.05%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	50.72%	50.72%	49.76%	46.25%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	85.02%	83.82%	84.30%	83.54%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	45.65%	42.27%	48.07%	41.65%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	37.44%	36.96%	37.68%	36.08%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	78.99%	79.23%	79.95%	80.15%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	78.26%	79.47%	81.64%	84.99%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	41.55%	42.03%	39.37%	47.46%	▼
Controlling High Blood Pressure	Q	—	—	61.59%	57.14%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	60.53%	72.15%	73.12%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	79.80%	67.42%	↓
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	57.70%	45.71%	↓
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**55.31%**	61.26%	**55.80%**	**54.24%**	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	82.13%	80.63%	85.75%	79.90%	↓
Use of Imaging Studies for Low Back Pain	Q	80.18%	81.64%	80.14%	80.40%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	65.62%	64.65%	71.91%	71.84%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	68.28%	70.22%	74.58%	73.06%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	58.35%	57.63%	67.31%	62.62%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	80.63%	77.54%	72.46%	69.49%	↔

Table A.38—Performance Measure Results
Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino Counties

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.65%	14.03%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	43.22	43.60	39.94	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	285.69	260.50	206.96	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**81.55%**	86.05%	87.83%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	92.11%	95.56%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**81.41%**	84.41%	86.60%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	21.50%	20.13%	30.23%	27.64%	↔
Cervical Cancer Screening	Q,A	—	—	—	60.81%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	**53.04%**	**59.63%**	**63.86%**	69.57%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**94.88%**	**93.65%**	**92.67%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**83.76%**	**83.03%**	**85.02%**	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**82.68%**	**81.96%**	**85.15%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**84.19%**	**84.51%**	**83.63%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	58.09%	59.33%	56.52%	59.60%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	**37.36%**	54.83%	46.68%	50.99%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	78.13%	78.65%	81.92%	82.56%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	**34.40%**	40.00%	43.48%	**38.19%**	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	28.70%	34.83%	35.93%	34.00%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	75.63%	77.30%	82.61%	79.69%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	79.73%	81.80%	83.30%	81.90%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	**55.58%**	48.76%	43.71%	48.79%	↔
Controlling High Blood Pressure	Q	—	—	53.83%	**47.22%**	↓
Immunizations for Adolescents—Combination 1	Q,A,T	—	60.88%	69.10%	73.77%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**31.87%**	**43.36%**	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**14.51%**	25.22%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**50.88%**	**43.84%**	**28.99%**	**47.46%**	↑

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**68.58%**	**77.17%**	**64.27%**	**71.52%**	↑
Use of Imaging Studies for Low Back Pain	Q	76.13%	76.40%	78.21%	77.08%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	42.46%	44.32%	42.00%	55.19%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	55.22%	64.97%	59.40%	66.00%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	44.08%	57.08%	49.42%	57.40%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	71.50%	74.77%	68.39%	72.73%	↔

Table A.39—Performance Measure Results
Molina Healthcare of California Partner Plan, Inc.—Sacramento County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	13.20%	13.71%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	44.96	47.83	50.20	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	238.15	261.22	257.68	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**78.84%**	**73.99%**	**79.52%**	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	NA	**82.86%**	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**74.23%**	**73.63%**	**79.48%**	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	27.19%	28.29%	23.08%	32.39%	↑
Cervical Cancer Screening	Q,A	—	—	—	60.63%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	**54.31%**	**50.12%**	**54.06%**	**59.42%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	95.79%	**94.81%**	**94.51%**	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**84.21%**	**84.09%**	**83.89%**	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**83.45%**	**83.80%**	**82.85%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**83.38%**	**84.20%**	**80.58%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	59.62%	58.22%	54.65%	**52.76%**	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	48.83%	56.22%	47.91%	48.79%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	79.34%	81.78%	78.60%	79.25%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	45.77%	46.89%	46.05%	45.25%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	36.15%	33.78%	31.63%	34.44%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	69.48%	**69.33%**	**70.00%**	75.28%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	77.00%	83.11%	80.47%	79.47%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	41.78%	40.89%	43.26%	46.36%	↔
Controlling High Blood Pressure	Q	—	—	51.29%	**47.23%**	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	55.32%	66.04%	67.33%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**31.72%**	51.36%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**17.24%**	22.27%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**49.44%**	**51.36%**	**37.47%**	**43.93%**	↑

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**73.27%**	81.45%	**69.62%**	**74.39%**	↔
Use of Imaging Studies for Low Back Pain	Q	78.95%	84.03%	83.24%	81.50%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	61.95%	62.33%	54.61%	45.70%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	62.65%	64.65%	59.34%	56.51%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	55.68%	58.37%	49.65%	49.89%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.49%	76.10%	73.21%	**67.31%**	↔

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

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.45%	14.93%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	43.3	45.58	40.54	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	331.91	305.90	228.23	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	86.72%	85.15%	86.03%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	94.74%	**79.66%**	↓
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	85.85%	86.01%	87.07%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	**17.28%**	**18.21%**	**17.33%**	28.29%	↑
Cervical Cancer Screening	Q,A	—	—	—	68.11%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	72.33%	73.19%	75.00%	76.89%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**94.76%**	95.93%	95.73%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	88.46%	88.02%	88.81%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**87.55%**	88.31%	89.06%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**83.75%**	**85.26%**	86.20%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	70.40%	62.00%	62.30%	60.71%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	49.33%	56.44%	58.55%	55.63%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	82.06%	84.44%	88.76%	87.64%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	42.60%	46.22%	57.85%	49.45%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	35.65%	42.22%	47.54%	40.18%	↓
Comprehensive Diabetes Care—LDL-C Screening	Q,A	76.91%	78.22%	86.42%	82.12%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	77.35%	80.22%	84.31%	84.99%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	48.21%	46.67%	32.55%	41.50%	▼
Controlling High Blood Pressure	Q	—	—	52.76%	53.88%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	71.30%	80.83%	81.44%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**35.33%**	45.12%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**18.63%**	25.18%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	63.19%	61.40%	**51.52%**	64.68%	↑

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.59%	88.94%	**79.72%**	83.00%	↔
Use of Imaging Studies for Low Back Pain	Q	77.66%	**71.98%**	**72.00%**	**68.64%**	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	53.01%	57.67%	64.79%	68.30%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	58.56%	61.86%	65.96%	62.28%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	54.63%	52.33%	55.16%	53.57%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	74.71%	78.89%	74.74%	74.29%	↔

Table A.41—Performance Measure Results
Partnership HealthPlan of California—Marin County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	16.04%	16.45%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	48.34	43.50	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	304.46	342.84	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	**76.74%**	84.90%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	**76.71%**	87.77%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	NA	46.15%	Not Comparable
Cervical Cancer Screening	Q,A	—	—	—	74.45%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	78.35%	75.35%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	98.76%	99.10%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	87.69%	90.64%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	**87.25%**	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	**84.18%**	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	60.71%	70.29%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	**42.46%**	49.64%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	87.70%	88.77%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	50.40%	48.91%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	34.13%	40.22%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	71.03%	76.45%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	79.37%	83.70%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	40.08%	43.84%	↔
Controlling High Blood Pressure	Q	—	—	50.65%	64.77%	↑
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	67.47%	75.00%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	NA	**43.64%**	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	NA	24.55%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	**57.75%**	67.63%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	**78.17%**	84.89%	↔
Use of Imaging Studies for Low Back Pain	Q	—	—	85.71%	S	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	83.33%	83.70%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	63.89%	68.86%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	44.44%	60.10%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	67.59%	75.83%	↑

Table A.42—Performance Measure Results
Partnership HealthPlan of California—Mendocino County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	9.81%	11.46%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	—	57.94	56.02	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	—	331.59	308.59	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	—	84.48%	**82.37%**	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	—	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	—	85.61%	**80.80%**	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	—	—	28.57%	48.05%	↑
Cervical Cancer Screening	Q,A	—	—	—	66.18%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	—	—	**61.86%**	**61.08%**	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	—	**95.45%**	95.80%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	—	89.15%	88.64%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	—	NA	88.51%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	—	NA	88.35%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	—	—	57.18%	63.74%	↑
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	—	—	**38.86%**	**39.34%**	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	—	—	92.82%	82.64%	↓
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	—	—	49.75%	41.32%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	—	—	37.38%	29.23%	↓
Comprehensive Diabetes Care—LDL-C Screening	Q,A	—	—	76.73%	**65.71%**	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	—	—	78.71%	75.16%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	—	—	37.38%	49.67%	▼
Controlling High Blood Pressure	Q	—	—	57.43%	59.55%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	—	51.46%	**57.65%**	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	NA	62.58%	Not Comparable
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	NA	32.52%	Not Comparable
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	69.68%	64.94%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	88.01%	83.33%	↔
Use of Imaging Studies for Low Back Pain	Q	—	—	88.05%	85.48%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	69.91%	77.86%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	55.79%	51.58%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	31.71%	36.98%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	**62.04%**	**63.92%**	↔

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

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	13.25%	15.60%	▼
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	47.82	52.33	53.57	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	256.88	312.13	311.38	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**82.13%**	84.46%	89.71%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	**80.88%**	90.48%	94.44%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**82.38%**	**82.35%**	89.42%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	26.08%	42.76%	33.18%	34.31%	↔
Cervical Cancer Screening	Q,A	—	—	—	69.59%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	70.14%	71.93%	68.87%	72.32%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**94.91%**	96.49%	96.81%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**82.91%**	**86.42%**	87.79%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**80.35%**	**83.67%**	**85.84%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**77.25%**	**84.94%**	**83.80%**	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	60.31%	69.27%	66.67%	65.21%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	54.77%	56.79%	53.42%	60.34%	↑
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.04%	86.64%	85.65%	82.48%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	54.77%	60.58%	53.64%	52.31%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	49.89%	49.22%	42.16%	46.96%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	79.38%	78.17%	77.70%	77.86%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	78.49%	83.74%	84.33%	86.86%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	34.59%	28.73%	35.76%	37.47%	↔
Controlling High Blood Pressure	Q	—	—	53.86%	56.72%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	56.81%	65.33%	64.10%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	59.90%	61.68%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	39.41%	40.23%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	69.51%	70.29%	75.92%	68.85%	↓

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	89.02%	87.27%	81.41%	80.00%	↔
Use of Imaging Studies for Low Back Pain	Q	88.42%	88.52%	88.95%	89.17%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	57.41%	74.77%	77.44%	69.76%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	49.77%	65.05%	67.91%	65.12%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	42.13%	53.70%	52.79%	54.15%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	67.54%	74.34%	74.26%	73.83%	↔

Table A.44—Performance Measure Results
Partnership HealthPlan of California—Sonoma County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	13.05%	12.79%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	43.17	44.10	39.40	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	283.01	345.59	354.14	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**71.41%**	**69.27%**	**84.41%**	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	88.57%	**85.29%**	88.89%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**73.94%**	**72.08%**	85.05%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	20.97%	47.47%	27.33%	36.96%	↔
Cervical Cancer Screening	Q,A	—	—	—	72.02%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	71.00%	76.62%	74.01%	79.13%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	95.24%	96.25%	98.23%	↑
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	**86.47%**	88.58%	90.32%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	**83.26%**	**85.70%**	**87.25%**	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	**84.36%**	88.23%	86.73%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	62.22%	76.12%	69.98%	70.56%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	49.56%	54.24%	57.62%	60.10%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	87.33%	90.18%	92.27%	89.05%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	51.78%	59.38%	51.66%	52.55%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	38.44%	43.75%	39.74%	41.12%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	**68.89%**	74.33%	76.60%	79.81%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	77.33%	80.13%	80.13%	82.24%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	37.11%	27.01%	34.88%	34.55%	↔
Controlling High Blood Pressure	Q	—	—	54.53%	60.69%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	53.01%	65.66%	74.93%	↑
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	63.71%	61.42%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	41.62%	44.29%	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	67.06%	75.69%	73.73%	74.14%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	88.15%	82.96%	85.97%	89.10%	↔
Use of Imaging Studies for Low Back Pain	Q	90.15%	90.42%	90.32%	90.56%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	77.31%	86.31%	87.15%	85.12%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	54.40%	69.37%	68.46%	65.12%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	47.69%	54.99%	51.64%	56.83%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	71.69%	72.16%	74.43%	81.31%	↑

Table A.45—Performance Measure Results
San Francisco Health Plan—San Francisco County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	15.81%	13.86%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	26.68	35.34	33.03	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	354.39	348.95	383.10	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	**73.20%**	**76.81%**	87.32%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	NA	**81.82%**	95.92%	↑
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	**71.43%**	**78.74%**	86.31%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	44.53%	45.45%	53.75%	44.01%	↓
Cervical Cancer Screening	Q,A	—	—	—	74.47%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	87.27%	87.04%	85.81%	85.42%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	**92.98%**	95.95%	97.01%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	87.90%	89.57%	92.55%	↑
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	90.08%	93.16%	94.70%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	86.78%	91.13%	91.04%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	73.71%	78.64%	74.77%	76.57%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	70.10%	69.72%	67.59%	62.41%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	90.38%	91.08%	90.97%	89.33%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	64.09%	63.38%	62.27%	63.57%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	47.94%	48.83%	47.69%	47.80%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	83.16%	83.33%	80.56%	79.35%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	85.05%	83.57%	87.73%	86.77%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	26.29%	26.53%	26.39%	24.36%	↔
Controlling High Blood Pressure	Q	—	—	66.46%	63.42%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	64.35%	81.02%	81.71%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**42.82%**	52.10%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**21.55%**	32.87%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	63.57%	75.64%	71.76%	70.40%	↔

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	90.26%	93.44%	87.96%	93.24%	↑
Use of Imaging Studies for Low Back Pain	Q	82.23%	82.98%	86.53%	84.86%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	60.65%	76.16%	85.19%	86.81%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	78.47%	80.56%	85.19%	82.41%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	70.37%	72.69%	83.80%	79.17%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	85.19%	84.95%	84.26%	86.81%	↔

Table A.46—Performance Measure Results
Santa Clara Family Health Plan—Santa Clara County

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	13.77%	15.20%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	‡	—	35.89	34.79	32.64	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	‡	—	292.77	267.45	260.02	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	86.05%	87.60%	87.39%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	**87.18%**	88.10%	89.01%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	84.85%	88.08%	87.91%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	31.41%	25.81%	26.43%	29.40%	↔
Cervical Cancer Screening	Q,A	—	—	—	67.40%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	79.40%	80.05%	73.72%	75.43%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.22%	96.87%	97.15%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	88.63%	88.90%	88.94%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	89.69%	88.92%	90.46%	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	86.78%	87.81%	87.46%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	62.70%	**45.01%**	**53.53%**	56.69%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	51.52%	47.69%	**41.85%**	46.72%	↔
Comprehensive Diabetes Care—HbA1c Testing	Q,A	84.38%	86.62%	86.62%	86.86%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	56.41%	51.09%	55.47%	54.01%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	51.28%	37.96%	42.82%	41.36%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	78.32%	81.02%	79.08%	81.02%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	76.22%	80.05%	79.81%	83.45%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	34.73%	40.88%	34.79%	33.82%	↔
Controlling High Blood Pressure	Q	—	—	52.80%	52.55%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	69.34%	75.67%	75.43%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	58.61%	61.13%	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	35.95%	41.98%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	62.73%	**58.39%**	67.40%	59.61%	↓

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.56%	82.73%	82.97%	86.13%	↔
Use of Imaging Studies for Low Back Pain	Q	82.30%	80.37%	82.42%	86.37%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	60.88%	64.23%	66.91%	71.53%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	61.81%	63.99%	67.88%	67.40%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	40.05%	45.74%	41.85%	49.15%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.61%	75.67%	72.75%	69.59%	↔

Specialty Managed Care Health Plans

Table A.47—Performance Measure Results
AIDS Healthcare Centers—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2012[3]	2013[4]	2014[5]	Performance Comparison[6]
*Controlling High Blood Pressure (CBP) 18–85 years**	Q,A	68.2%	62.20%	61.07%	↔
Colorectal Cancer Screening (COL) 50–75 years^	Q,A	64.2%	63.07%	**52.04%**	↓

[1] DHCS-selected HEDIS performance measures developed by NCQA.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011. 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.
[4] HEDIS 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] HEDIS 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[6] Performance comparisons are based on the Chi-square test of statistical significance with a p value of <0.05.
* The minimum performance level (MPL) and high performance level (HPL) for this measure are based on NCQA's national Medicaid 25th and 90th percentiles, respectively.
^ The MPL and HPL for this measure are based on NCQA's national commercial 25th and 90th percentiles, respectively, since no Medicaid benchmarks are available for this measure.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.

Table A.48—Performance Measure Results
Family Mosaic Project—San Francisco County
Out-of-Home Placements*

Year	2012	2013	2014	Performance Comparison[2]
Rate[1]	6.3%	4.1%	S	↔

* No MPL or HPL is established for this measure.
[1] The rate for this measure was reported to one decimal place in 2012 and 2013; however, in 2014, the rate was reported to two decimal places. Additionally, for this measure, a low rate indicates better performance.
[2] The 2014 rates were compared to the 2013 rates to determine if there were any statistically significant differences between the two rates. Performance comparisons were based on the Chi-square test of statistical significance with a *p* value of <0.05.
S = The MCP's measure was reportable based on performance measure validation audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.

Table A.49—Comparison of 2012 and 2013 Performance Measure Results
Family Mosaic Project—San Francisco County
School Attendance*

Year	2014
Rate[1]	S

* No MPL or HPL is established for this measure. Additionally, 2014 was the first year Family Mosaic Project reported this measure so no analysis or comparisons can be made.
[1] For this measure, a low rate indicates better performance.
S = The MCP's measure was reportable based on performance measure validation audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table A.50—Performance Measure Results
SCAN Health Plan—Los Angeles/Riverside/San Bernardino Counties

Performance Measure[1]	Domain of Care[2]	2012[3]	2013[4]	2014[5]	Performance Comparison[6]
*Breast Cancer Screening**	Q, A	79.9%	81.42%	79.90%	↓
*Osteoporosis Management in Women Who Had a Fracture^*	Q, T	27.7%	28.40%	41.14%	↑

[1] DHCS-selected HEDIS performance measures developed by NCQA.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011. 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 and 2014 rates.
[4] HEDIS 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] HEDIS 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[6] Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.
* The minimum performance level (MPL) and high performance level (HPL) for this measure are based on NCQA's national Medicaid 25th and 90th percentiles, respectively.
^ The MPL and HPL for this measure are based on NCQA's national Medicare 25th and 90th percentiles, respectively, since no Medicaid benchmarks are available for this measure.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.

APPENDIX B. INDIVIDUAL FULL-SCOPE MANAGED CARE HEALTH PLAN SPD AND NON-SPD RATES

The following key applies to the tables below, which contain 2014 performance measure comparisons 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 2014 were significantly higher than the non-SPD rates.
↓	SPD rates in 2014 were significantly lower than the non-SPD rates.
↔	SPD rates in 2014 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%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
Not Comparable	A rate comparison could not be made because data were not available for both populations.
NA	A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).
S	The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table B.1—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	13.64%	19.54%	▼	17.42%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.91%	84.69%	↑	83.78%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	92.80%	Not Comparable	93.43%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.90%	85.18%	↑	84.34%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.25%	100.0%	↔	94.34%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	85.07%	86.01%	↔	85.10%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	87.03%	87.57%	↔	87.07%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	83.59%	79.65%	↓	83.24%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	61.63%	56.93%	↔	57.66%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	44.06%	43.55%	↔	45.26%
Comprehensive Diabetes Care—HbA1c Testing	77.48%	84.43%	↑	81.75%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	44.80%	54.74%	↑	48.18%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.47%	30.90%	↔	29.20%
Comprehensive Diabetes Care—LDL-C Screening	63.86%	78.10%	↑	71.29%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.76%	85.16%	↑	80.05%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	55.20%	45.26%	▲	51.82%

Table B.2—2014 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
212.26	24.72	387.05	53.35

Table B.3—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	10.91%	19.74%	▼	18.16%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	71.79%	83.77%	↑	81.73%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	70.77%	82.80%	↑	80.81%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	85.30%	NA	Not Comparable	85.16%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	77.79%	78.70%	↔	77.82%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	78.54%	79.11%	↔	78.58%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	75.79%	70.43%	↓	75.18%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	46.33%	38.72%	↓	38.41%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	36.68%	34.96%	↔	35.10%
Comprehensive Diabetes Care—HbA1c Testing	73.36%	77.88%	↔	75.94%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	27.41%	27.88%	↔	26.05%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	15.06%	19.91%	↔	17.66%
Comprehensive Diabetes Care—LDL-C Screening	55.60%	66.81%	↑	61.37%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	66.02%	78.32%	↑	73.95%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	66.41%	66.15%	↔	67.55%

Table B.4—2014 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
187.84	53.18	294.17	115.98

Table B.5—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	19.78%	↔	17.30%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	76.47%	81.38%	↔	80.33%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	67.35%	78.77%	↔	75.90%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.23%	NA	Not Comparable	95.12%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	86.31%	89.36%	↔	86.44%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.35%	87.61%	↔	88.29%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	85.16%	83.50%	↔	84.96%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	48.96%	44.57%	↔	46.13%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	40.63%	36.00%	↔	37.64%
Comprehensive Diabetes Care—HbA1c Testing	72.92%	76.57%	↔	75.28%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	40.63%	33.71%	↔	36.16%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	21.88%	33.71%	↑	29.52%
Comprehensive Diabetes Care—LDL-C Screening	62.50%	69.71%	↔	67.16%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.75%	84.00%	↑	78.60%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	54.17%	58.29%	↔	56.83%

Table B.6—2014 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
225.26	56.15	284.86	97.01

Table B.7—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	10.68%	16.18%	▼	14.38%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.76%	83.57%	↔	82.80%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.59%	85.08%	↑	82.63%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	93.86%	NA	Not Comparable	93.76%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.33%	84.85%	↔	83.38%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	83.46%	84.70%	↔	83.51%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	79.14%	79.00%	↔	79.14%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	54.57%	50.88%	↔	52.44%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	42.09%	39.82%	↔	44.89%
Comprehensive Diabetes Care—HbA1c Testing	79.29%	78.98%	↔	79.33%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	33.85%	33.63%	↔	36.22%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.84%	28.54%	↔	30.89%
Comprehensive Diabetes Care—LDL-C Screening	73.27%	74.56%	↔	74.89%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	75.95%	80.75%	↔	80.22%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	54.12%	51.55%	↔	50.00%

Table B.8—2014 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
219.48	45.59	367.46	74.31

Table B.9—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	S	↔	8.43%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.56%	82.43%	↔	81.64%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	68.66%	83.70%	↑	77.36%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.71%	NA	Not Comparable	94.74%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.36%	80.00%	↔	83.25%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	84.26%	95.92%	↑	84.78%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.62%	84.93%	↔	84.64%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	60.74%	48.60%	↓	54.39%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	38.04%	42.46%	↔	40.35%
Comprehensive Diabetes Care—HbA1c Testing	72.39%	72.63%	↔	72.51%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	23.31%	27.93%	↔	25.73%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	14.72%	24.02%	↑	19.59%
Comprehensive Diabetes Care—LDL-C Screening	67.48%	69.27%	↔	68.42%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.62%	80.45%	↔	77.19%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	65.03%	64.80%	↔	64.91%

Table B.10—2014 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
291.39	61.93	563.40	119.47

Table B.11—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	S	↔	8.63%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.82%	86.18%	↔	84.36%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	68.42%	84.62%	↔	78.64%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.45%	NA	Not Comparable	98.47%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.87%	93.62%	↔	90.94%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.58%	97.44%	↔	90.80%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.52%	92.86%	↔	88.72%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.06%	62.84%	↔	61.09%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	56.69%	53.38%	↔	54.91%
Comprehensive Diabetes Care—HbA1c Testing	84.25%	84.46%	↔	84.36%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	44.09%	42.57%	↔	43.27%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	22.83%	34.46%	↑	29.09%
Comprehensive Diabetes Care—LDL-C Screening	67.72%	70.27%	↔	69.09%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.74%	82.43%	↔	80.73%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	44.88%	50.00%	↔	47.64%

Table B.12—2014 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
272.13	54.40	509.81	98.73

Table B.13—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.70%	13.26%	▼	11.83%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	75.38%	82.21%	↑	80.33%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	85.29%	Not Comparable	87.80%
Annual Monitoring for Patients on Persistent Medications—Diuretics	70.27%	83.72%	↑	80.50%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.06%	92.31%	↔	94.03%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	81.70%	78.10%	↓	81.58%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	80.76%	83.31%	↔	80.92%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	78.05%	79.13%	↔	78.14%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	57.74%	45.58%	↓	50.11%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	32.30%	38.94%	↑	37.75%
Comprehensive Diabetes Care—HbA1c Testing	70.80%	75.66%	↔	75.28%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	35.84%	41.59%	↔	40.18%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	25.22%	30.09%	↔	29.36%
Comprehensive Diabetes Care—LDL-C Screening	61.50%	67.70%	↔	64.68%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	67.70%	84.96%	↑	79.47%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	52.88%	47.12%	↔	47.68%

Table B.14—2014 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
191.26	48.19	356.44	82.77

Table B.15—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	17.38%	↔	16.67%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.42%	84.77%	↔	84.48%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.39%	84.60%	↔	84.19%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.95%	NA	Not Comparable	96.63%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.53%	70.97%	↓	89.05%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.73%	77.50%	↓	89.23%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.40%	88.35%	↔	88.40%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	66.04%	55.33%	↓	56.44%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	53.77%	48.67%	↔	49.78%
Comprehensive Diabetes Care—HbA1c Testing	83.02%	82.89%	↔	82.00%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	40.57%	44.67%	↔	44.44%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	25.47%	30.89%	↔	32.00%
Comprehensive Diabetes Care—LDL-C Screening	70.75%	70.44%	↔	70.44%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	75.47%	84.00%	↑	82.67%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	47.17%	47.56%	↔	47.56%

Table B.16—2014 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
245.67	35.87	373.20	95.72

Table B.17—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	6.88%	16.33%	▼	13.75%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.51%	89.63%	↑	87.64%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	79.27%	88.49%	↑	85.77%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.97%	NA	Not Comparable	95.43%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.66%	81.45%	↓	87.49%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.89%	86.89%	↔	89.72%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	85.77%	83.11%	↔	85.64%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	51.55%	40.84%	↓	44.15%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	46.90%	43.93%	↔	45.25%
Comprehensive Diabetes Care—HbA1c Testing	83.19%	84.33%	↔	83.00%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	44.25%	44.59%	↔	45.03%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	39.16%	37.09%	↔	40.40%
Comprehensive Diabetes Care—LDL-C Screening	78.54%	79.91%	↔	80.35%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.87%	82.78%	↔	80.13%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	42.04%	46.58%	↔	43.27%

Table B.18—2014 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
232.83	41.56	374.95	74.19

Table B.19—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.22%	12.83%	▼	10.59%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.20%	85.94%	↔	85.06%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.50%	87.12%	↑	84.53%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.77%	NA	Not Comparable	97.75%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.38%	89.09%	↔	90.35%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.28%	86.57%	↔	88.21%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.56%	86.76%	↔	87.52%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.20%	51.11%	↓	54.97%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.46%	42.70%	↔	47.02%
Comprehensive Diabetes Care—HbA1c Testing	81.82%	83.19%	↔	83.00%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	39.02%	39.82%	↔	42.60%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	30.60%	29.42%	↔	29.36%
Comprehensive Diabetes Care—LDL-C Screening	74.06%	71.46%	↔	73.07%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.61%	84.96%	↑	81.46%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	48.12%	47.79%	↔	46.36%

Table B.20—2014 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
305.19	39.20	561.54	83.89

Table B.21—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	10.83%	16.83%	▼	15.22%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.11%	91.90%	↑	90.55%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	90.06%	Not Comparable	89.69%
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.73%	91.16%	↑	89.62%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.54%	85.27%	↓	97.42%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.62%	85.47%	↓	91.43%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	92.64%	85.84%	↓	92.30%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	89.52%	80.71%	↓	89.07%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	74.77%	50.46%	↓	69.30%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	65.65%	63.89%	↔	67.91%
Comprehensive Diabetes Care—HbA1c Testing	83.88%	86.34%	↔	85.12%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.83%	57.64%	↑	59.07%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	46.96%	46.53%	↔	49.77%
Comprehensive Diabetes Care—LDL-C Screening	81.07%	86.81%	↑	84.88%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.97%	87.73%	↑	85.81%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.36%	33.33%	▲	32.33%

Table B.22—2014 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
226.81	32.50	573.24	51.03

Table B.23—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.78%	15.39%	▼	13.10%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.64%	85.27%	↔	84.64%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	82.26%	Not Comparable	80.77%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.23%	86.97%	↑	84.96%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.57%	100.00%	↔	96.60%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.06%	91.65%	↔	91.08%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	91.33%	93.33%	↑	91.42%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.45%	88.51%	↔	87.51%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	52.07%	55.47%	↔	54.26%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	43.80%	54.01%	↑	48.42%
Comprehensive Diabetes Care—HbA1c Testing	79.32%	81.75%	↔	79.81%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	36.50%	39.17%	↔	38.20%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	26.28%	34.79%	↑	32.12%
Comprehensive Diabetes Care—LDL-C Screening	66.42%	74.45%	↑	72.99%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	69.83%	81.27%	↑	76.89%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	57.18%	54.50%	↔	54.74%

Table B.24—2014 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
458.67	47.62	555.25	70.05

Table B.25—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	8.57%	↔	7.92%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.71%	91.32%	↑	87.21%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	74.56%	92.14%	↑	84.25%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.85%	NA	Not Comparable	94.68%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.44%	87.65%	↔	83.58%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	86.92%	90.00%	↔	87.06%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.55%	85.71%	↔	84.62%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	39.91%	46.98%	↔	45.50%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	37.22%	52.68%	↑	48.42%
Comprehensive Diabetes Care—HbA1c Testing	78.92%	80.87%	↔	78.59%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	37.22%	39.26%	↔	39.66%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.25%	34.56%	↔	32.12%
Comprehensive Diabetes Care—LDL-C Screening	73.54%	76.51%	↔	74.21%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.68%	80.20%	↔	78.10%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	55.61%	50.34%	↔	52.07%

Table B.26—2014 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
403.24	55.66	651.69	113.80

Table B.27—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	16.36%	▼	13.40%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.41%	85.77%	↔	83.06%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.42%	89.71%	↔	85.94%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.06%	NA	Not Comparable	98.08%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	93.38%	97.17%	↔	93.49%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	92.84%	94.29%	↔	92.88%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	90.76%	88.42%	↔	90.68%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	68.31%	57.53%	↓	64.96%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	59.08%	55.52%	↔	60.34%
Comprehensive Diabetes Care—HbA1c Testing	88.00%	89.63%	↔	88.32%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	44.62%	43.81%	↔	43.07%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.23%	36.12%	↔	34.31%
Comprehensive Diabetes Care—LDL-C Screening	74.46%	74.58%	↔	74.45%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.08%	87.63%	↑	82.00%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	47.69%	49.16%	↔	49.39%

Table B.28—2014 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
464.83	49.54	665.45	78.44

Table B.29—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.64%	16.90%	▼	15.57%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	76.14%	85.13%	↑	83.72%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	72.65%	85.98%	↑	83.96%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	89.78%	NA	Not Comparable	89.27%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	81.31%	69.03%	↓	80.91%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	81.93%	62.64%	↓	80.88%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	79.34%	70.67%	↓	78.71%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	51.18%	41.61%	↓	46.72%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.34%	36.98%	↔	37.71%
Comprehensive Diabetes Care—HbA1c Testing	82.28%	81.02%	↔	81.27%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	35.04%	44.04%	↑	42.58%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	26.77%	35.04%	↑	32.36%
Comprehensive Diabetes Care—LDL-C Screening	70.47%	72.51%	↔	72.99%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.62%	81.27%	↑	82.24%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	71.65%	64.72%	↔	51.82%

Table B.30—2014 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
237.00	44.72	399.63	68.85

Table B.31—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	6.71%	14.96%	▼	12.28%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	71.79%	83.97%	↑	80.16%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	72.97%	90.28%	↑	84.92%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.86%	NA	Not Comparable	96.78%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.04%	76.07%	↓	89.60%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.91%	83.22%	↓	90.47%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.41%	79.72%	↓	86.83%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	67.71%	68.56%	↔	65.94%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.81%	61.47%	↔	59.12%
Comprehensive Diabetes Care—HbA1c Testing	83.85%	83.85%	↔	84.18%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	50.00%	61.76%	↑	58.15%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.85%	45.04%	↑	40.15%
Comprehensive Diabetes Care—LDL-C Screening	77.60%	80.74%	↔	79.08%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.73%	88.39%	↑	85.40%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	35.94%	27.76%	▲	30.90%

Table B.32—2014 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
296.02	53.41	598.85	95.46

Table B.33—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.29%	16.41%	▼	13.15%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	79.54%	89.25%	↑	85.79%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	83.33%	Not Comparable	84.85%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.53%	89.19%	↑	86.74%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.48%	NA	Not Comparable	98.49%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	93.63%	90.99%	↔	93.58%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	92.99%	90.32%	↔	92.88%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	90.65%	89.52%	↔	90.59%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	71.53%	67.64%	↔	72.02%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	66.18%	66.18%	↔	68.61%
Comprehensive Diabetes Care—HbA1c Testing	84.18%	87.10%	↔	86.37%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	56.20%	63.50%	↑	59.37%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.98%	45.01%	↑	40.39%
Comprehensive Diabetes Care—LDL-C Screening	79.56%	79.32%	↔	80.05%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.02%	86.13%	↑	84.91%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	33.33%	26.76%	▲	31.87%

Table B.34—2014 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
272.79	46.42	596.56	102.10

Table B.35—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.00%	15.78%	▼	12.78%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.92%	90.10%	↑	86.87%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	83.33%
Annual Monitoring for Patients on Persistent Medications—Diuretics	79.91%	91.17%	↑	86.43%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.66%	NA	Not Comparable	97.63%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	91.67%	91.03%	↔	91.65%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.11%	94.07%	↑	90.31%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.58%	86.86%	↔	88.46%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	50.85%	43.31%	↓	62.53%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	49.64%	51.82%	↔	53.53%
Comprehensive Diabetes Care—HbA1c Testing	85.16%	88.32%	↔	83.94%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	36.01%	39.42%	↔	44.28%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	25.06%	28.47%	↔	32.85%
Comprehensive Diabetes Care—LDL-C Screening	78.35%	81.02%	↔	78.59%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.83%	86.86%	↑	81.27%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	57.18%	52.07%	↔	45.74%

Table B.36—2014 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
297.38	50.05	539.90	76.83

Table B.37—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.69%	13.89%	▼	11.58%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.28%	89.63%	↑	87.34%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	87.80%	Not Comparable	87.76%
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.85%	90.06%	↑	87.02%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.32%	NA	Not Comparable	98.31%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	92.06%	95.29%	↑	92.11%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	93.21%	92.34%	↔	93.18%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	91.08%	87.52%	↓	90.94%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.29%	59.85%	↔	75.18%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	51.09%	62.04%	↑	56.45%
Comprehensive Diabetes Care—HbA1c Testing	81.27%	88.08%	↑	86.86%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	40.15%	51.82%	↑	51.82%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	31.39%	37.96%	↑	35.77%
Comprehensive Diabetes Care—LDL-C Screening	73.97%	81.75%	↑	79.81%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	75.67%	82.97%	↑	79.32%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	50.36%	40.88%	▲	38.20%

Table B.38—2014 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
282.10	44.17	549.69	74.76

Table B.39—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	10.38%	14.88%	▼	13.28%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.18%	89.03%	↑	87.41%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	95.31%	Not Comparable	95.71%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.92%	90.33%	↑	88.16%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.94%	97.37%	↔	95.95%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.97%	88.30%	↔	89.92%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.39%	89.97%	↔	89.41%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	85.50%	84.81%	↔	85.47%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	47.93%	44.04%	↔	45.99%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	51.34%	57.18%	↔	55.47%
Comprehensive Diabetes Care—HbA1c Testing	82.73%	86.86%	↔	86.13%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	43.31%	46.47%	↔	45.01%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.85%	42.58%	↑	39.66%
Comprehensive Diabetes Care—LDL-C Screening	77.86%	82.97%	↔	81.75%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.72%	84.91%	↑	81.27%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	42.82%	39.66%	↔	40.88%

Table B.40—2014 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
280.48	35.06	384.72	46.05

Table B.41—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.53%	14.13%	▼	12.95%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.51%	87.41%	↑	86.52%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	95.00%	Not Comparable	95.45%
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.67%	85.24%	↔	85.11%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.62%	NA	Not Comparable	94.62%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	86.03%	87.47%	↔	86.07%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	86.72%	86.49%	↔	86.71%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	83.50%	82.72%	↔	83.44%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.37%	62.77%	↔	61.31%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	45.74%	52.55%	↔	51.34%
Comprehensive Diabetes Care—HbA1c Testing	79.32%	84.43%	↔	84.43%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	35.28%	54.01%	↑	48.18%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.12%	42.58%	↑	42.34%
Comprehensive Diabetes Care—LDL-C Screening	69.83%	75.91%	↑	75.67%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.94%	83.21%	↑	83.94%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	54.01%	36.98%	▲	41.61%

Table B.42—2014 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
223.77	48.06	342.49	74.83

Table B.43—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.53%	15.06%	▼	13.08%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.52%	89.11%	↔	88.47%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	92.50%	Not Comparable	93.33%
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.58%	90.10%	↔	89.51%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.46%	89.74%	↓	97.37%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	86.35%	83.61%	↔	86.27%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	82.53%	77.69%	↓	82.26%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	79.68%	72.72%	↓	79.18%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	60.83%	59.85%	↔	61.31%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	42.34%	44.04%	↔	45.74%
Comprehensive Diabetes Care—HbA1c Testing	84.43%	85.16%	↔	85.16%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.01%	49.88%	↔	45.50%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	25.30%	34.79%	↑	28.47%
Comprehensive Diabetes Care—LDL-C Screening	77.37%	80.05%	↔	79.56%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	75.67%	81.51%	↑	78.10%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	46.47%	42.34%	↔	45.50%

Table B.44—2014 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
189.20	35.36	361.16	64.02

Table B.45—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.35%	12.18%	↔	11.50%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.73%	80.38%	↓	82.19%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.89%	81.49%	↔	81.82%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	93.14%	NA	Not Comparable	92.95%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	79.32%	73.87%	↔	79.16%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	67.84%	70.16%	↔	67.96%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	67.83%	63.26%	↔	67.50%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	52.31%	48.66%	↔	50.36%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	44.53%	46.72%	↔	42.34%
Comprehensive Diabetes Care—HbA1c Testing	78.10%	79.32%	↔	76.89%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	27.25%	39.17%	↑	33.33%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	25.06%	40.63%	↑	35.52%
Comprehensive Diabetes Care—LDL-C Screening	70.56%	77.62%	↑	74.45%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.16%	82.48%	↑	79.32%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	64.48%	54.50%	▲	60.10%

Table B.46—2014 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
359.51	48.90	302.99	83.64

Table B.47—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	6.53%	13.40%	▼	11.64%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	77.70%	81.62%	↑	80.35%
Annual Monitoring for Patients on Persistent Medications—Digoxin	80.00%	87.45%	↔	86.38%
Annual Monitoring for Patients on Persistent Medications—Diuretics	76.55%	82.59%	↑	80.78%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.70%	73.01%	↓	94.47%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	81.27%	78.05%	↓	81.18%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	82.04%	81.11%	↔	81.99%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	77.67%	73.04%	↓	77.41%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	64.72%	53.04%	↓	59.61%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	51.34%	48.42%	↔	50.36%
Comprehensive Diabetes Care—HbA1c Testing	81.75%	79.56%	↔	79.81%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	39.66%	45.01%	↔	45.26%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	30.90%	39.17%	↑	37.23%
Comprehensive Diabetes Care—LDL-C Screening	74.94%	78.83%	↔	77.62%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.29%	83.45%	↔	81.27%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	50.85%	45.50%	↔	48.66%

Table B.48—2014 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
277.13	32.38	262.13	52.60

Table B.49—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.16%	13.70%	▼	12.69%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	67.61%	74.02%	↑	72.60%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	84.75%	Not Comparable	84.75%
Annual Monitoring for Patients on Persistent Medications—Diuretics	63.48%	72.64%	↑	70.56%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	92.50%	97.22%	↔	92.57%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	81.11%	79.88%	↔	81.06%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	79.18%	83.38%	↔	79.43%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	75.14%	73.71%	↔	75.02%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	49.39%	47.20%	↔	45.99%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	35.77%	41.12%	↔	37.96%
Comprehensive Diabetes Care—HbA1c Testing	71.29%	78.10%	↑	77.62%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	38.44%	48.91%	↑	48.18%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	26.28%	35.28%	↑	33.33%
Comprehensive Diabetes Care—LDL-C Screening	63.75%	71.29%	↑	67.64%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	71.53%	82.00%	↑	80.29%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	54.99%	43.80%	▲	46.23%

Table B.50—2014 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
293.32	39.23	358.78	64.11

Table B.51—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.87%	17.37%	▼	15.90%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.47%	90.18%	↑	89.08%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.26%	90.62%	↑	88.33%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.17%	NA	Not Comparable	95.87%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.28%	75.61%	↓	87.67%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	86.55%	81.54%	↔	86.20%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	82.56%	77.03%	↓	82.09%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	46.58%	46.47%	↔	46.23%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.26%	38.93%	↔	44.77%
Comprehensive Diabetes Care—HbA1c Testing	68.49%	76.16%	↔	77.13%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	34.93%	40.15%	↔	38.69%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	25.34%	33.09%	↔	30.90%
Comprehensive Diabetes Care—LDL-C Screening	63.01%	70.07%	↔	70.32%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	69.86%	80.29%	↑	78.10%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	56.16%	53.28%	↔	54.01%

Table B.52—2014 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
362.03	41.81	319.25	69.30

Table B.53—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Net Community Solutions, Inc.—San Joaquin County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	NA	25.00%	Not Comparable	18.60%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	57.45%	75.47%	↔	67.00%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	NA	NA	Not Comparable	65.45%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	91.89%	NA	Not Comparable	92.11%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	76.48%	NA	Not Comparable	76.97%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	NA	Not Comparable	NA
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	NA	Not Comparable	NA
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	36.51%	33.33%	↔	34.96%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	34.92%	43.33%	↔	39.02%
Comprehensive Diabetes Care—HbA1c Testing	60.32%	86.67%	↑	73.17%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	20.63%	38.33%	↑	29.27%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	17.46%	40.00%	↑	28.46%
Comprehensive Diabetes Care—LDL-C Screening	60.32%	60.00%	↔	60.16%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.19%	86.67%	↔	81.30%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	74.60%	55.00%	▲	65.04%

Table B.54—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Net Community Solutions, Inc.—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
256.64	46.94	344.91	104.16

Table B.55—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	13.24%	▼	10.97%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.05%	84.15%	↔	83.17%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	79.47%	86.17%	↑	84.38%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.53%	NA	Not Comparable	95.59%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	85.74%	86.32%	↔	85.89%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	86.32%	87.57%	↔	86.39%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	83.89%	83.08%	↔	83.84%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.99%	55.72%	↓	58.64%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.61%	40.39%	↔	41.36%
Comprehensive Diabetes Care—HbA1c Testing	82.97%	87.10%	↔	87.10%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.23%	54.01%	↑	51.82%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.06%	42.34%	↑	41.36%
Comprehensive Diabetes Care—LDL-C Screening	73.48%	77.86%	↔	77.62%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	71.05%	81.75%	↑	78.35%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	42.09%	36.50%	↔	37.23%

Table B.56—2014 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
378.60	56.78	470.09	93.41

Table B.57—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.62%	12.77%	↔	11.74%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.29%	84.40%	↔	84.77%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	90.00%	Not Comparable	91.43%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.40%	85.63%	↔	84.10%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.57%	NA	Not Comparable	97.60%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	92.05%	90.20%	↔	91.99%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	91.06%	94.23%	↔	91.23%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	89.35%	90.40%	↔	89.42%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	60.34%	55.96%	↔	55.96%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	40.88%	50.85%	↑	50.12%
Comprehensive Diabetes Care—HbA1c Testing	79.08%	80.29%	↔	79.56%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	41.61%	48.42%	↑	45.26%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.47%	33.82%	↔	30.66%
Comprehensive Diabetes Care—LDL-C Screening	71.78%	70.80%	↔	69.34%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	71.53%	84.18%	↑	79.56%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	51.09%	44.77%	↔	47.45%

Table B.58—2014 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
486.43	38.64	651.79	70.74

Table B.59—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	6.86%	13.65%	▼	11.06%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.28%	85.07%	↑	83.80%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	93.18%	Not Comparable	94.12%
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.14%	86.24%	↑	84.29%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.00%	100.0%	↔	97.04%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.86%	86.09%	↔	87.79%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	86.67%	87.37%	↔	86.70%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	83.07%	85.91%	↑	83.23%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.61%	69.10%	↑	65.69%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.85%	42.34%	↔	44.77%
Comprehensive Diabetes Care—HbA1c Testing	72.02%	81.75%	↑	79.08%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	43.80%	56.45%	↑	51.82%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	32.12%	46.72%	↑	41.12%
Comprehensive Diabetes Care—LDL-C Screening	68.86%	78.10%	↑	75.18%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.37%	84.18%	↑	79.08%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	47.69%	36.25%	▲	40.15%

Table B.60—2014 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
223.43	42.34	438.00	71.99

Table B.61—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Health Plan of San Joaquin—Stanislaus County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.67%	15.88%	▼	13.11%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.48%	87.72%	↑	84.64%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.05%	89.27%	↔	87.39%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.21%	NA	Not Comparable	97.23%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.33%	93.20%	↔	88.43%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.87%	NA	Not Comparable	88.90%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	86.62%	NA	Not Comparable	86.60%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	66.58%	66.42%	↔	67.88%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	31.78%	39.17%	↑	37.23%
Comprehensive Diabetes Care—HbA1c Testing	83.01%	88.56%	↑	85.40%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.22%	59.37%	↑	52.31%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	39.73%	43.55%	↔	40.63%
Comprehensive Diabetes Care—LDL-C Screening	72.33%	81.75%	↑	74.94%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.16%	83.70%	↑	80.29%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.37%	31.14%	▲	36.98%

Table B.62—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
Health Plan of San Joaquin—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
244.19	51.51	585.69	105.58

Table B.63—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	11.52%	16.78%	▼	15.68%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.57%	91.58%	↑	90.97%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	94.84%	Not Comparable	94.34%
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.05%	92.65%	↑	91.85%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.15%	NA	Not Comparable	97.13%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.80%	77.57%	↓	90.40%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.92%	72.88%	↓	89.74%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	86.89%	68.15%	↓	85.34%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	52.31%	46.72%	↔	46.72%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.36%	63.99%	↑	60.83%
Comprehensive Diabetes Care—HbA1c Testing	81.75%	88.81%	↑	87.10%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	47.93%	56.93%	↑	54.01%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.50%	47.20%	↑	42.82%
Comprehensive Diabetes Care—LDL-C Screening	75.43%	84.91%	↑	80.78%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.00%	90.75%	↑	90.02%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	43.07%	36.01%	▲	38.69%

Table B.64—2014 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
326.37	44.87	797.31	60.39

Table B.65—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Inland Empire Health Plan—Riverside/San Bernardino Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.67%	17.37%	▼	14.73%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.43%	88.35%	↑	86.33%
Annual Monitoring for Patients on Persistent Medications—Digoxin	85.19%	91.64%	↔	90.80%
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.92%	87.55%	↑	85.42%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.70%	94.61%	↔	96.67%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	86.81%	85.58%	↔	86.77%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	84.46%	86.46%	↑	84.55%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.06%	82.45%	↓	83.97%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	67.26%	60.18%	↓	62.88%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	46.46%	56.11%	↑	51.74%
Comprehensive Diabetes Care—HbA1c Testing	78.98%	87.33%	↑	84.69%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	42.48%	50.68%	↑	46.87%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.29%	43.21%	↑	40.60%
Comprehensive Diabetes Care—LDL-C Screening	76.33%	85.29%	↑	81.67%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	75.44%	89.37%	↑	82.13%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	49.56%	33.71%	▲	39.44%

Table B.66—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
Inland Empire Health Plan—Riverside/San Bernardino Counties

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
247.47	44.44	632.06	82.89

Table B.67—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Kaiser North—Sacramento County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	12.14%	17.24%	↔	16.07%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	93.08%	96.00%	↑	95.24%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.16%	96.55%	↑	95.09%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	99.48%	NA	Not Comparable	99.48%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.06%	93.75%	↑	88.25%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	83.92%	96.33%	↑	84.70%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	85.09%	93.19%	↑	85.87%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	79.51%	80.20%	↔	80.00%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	58.49%	66.44%	↑	64.11%
Comprehensive Diabetes Care—HbA1c Testing	91.64%	95.64%	↑	94.47%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.09%	65.66%	↑	59.92%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	54.99%	74.50%	↑	68.77%
Comprehensive Diabetes Care—LDL-C Screening	90.30%	94.41%	↑	93.20%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	89.49%	95.08%	↑	93.44%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	38.01%	23.15%	▲	27.51%

Table B.68—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
Kaiser North—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
313.74	41.86	699.94	84.30

Table B.69—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Kaiser South—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	11.46%	11.41%	↔	11.42%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.99%	96.68%	↑	93.76%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.03%	96.13%	↔	93.57%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	99.50%	NA	Not Comparable	99.51%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	93.49%	98.80%	↔	93.60%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.42%	99.08%	↑	89.97%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.65%	96.32%	↑	88.17%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	88.89%	88.84%	↔	88.86%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	79.06%	82.96%	↔	81.71%
Comprehensive Diabetes Care—HbA1c Testing	96.15%	96.75%	↔	96.56%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	61.97%	72.62%	↑	69.19%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	58.12%	74.44%	↑	69.19%
Comprehensive Diabetes Care—LDL-C Screening	92.74%	95.74%	↔	94.77%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	92.74%	95.94%	↔	94.91%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	21.37%	16.23%	↔	17.88%

Table B.70—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
Kaiser South—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
343.04	26.61	890.21	59.41

Table B.71—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	11.62%	18.74%	▼	14.94%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.05%	90.14%	↔	88.95%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	93.33%	Not Comparable	93.48%
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.03%	91.41%	↑	89.62%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	93.25%	92.59%	↔	93.24%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	84.37%	84.46%	↔	84.37%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	81.42%	79.50%	↔	81.39%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	80.64%	78.43%	↔	80.60%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	76.89%	72.75%	↔	75.67%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.20%	44.77%	↔	45.01%
Comprehensive Diabetes Care—HbA1c Testing	80.29%	80.78%	↔	80.05%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.72%	49.39%	↔	44.53%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.79%	40.15%	↔	37.71%
Comprehensive Diabetes Care—LDL-C Screening	77.37%	80.78%	↔	77.86%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.81%	83.21%	↔	82.48%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	47.69%	38.20%	▲	46.96%

Table B.72—2014 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
248.15	46.93	492.89	99.42

Table B.73—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.19%	18.44%	▼	15.50%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	78.24%	79.22%	↑	78.93%
Annual Monitoring for Patients on Persistent Medications—Digoxin	89.77%	79.65%	↓	80.72%
Annual Monitoring for Patients on Persistent Medications—Diuretics	77.33%	78.52%	↔	78.17%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	91.98%	79.34%	↓	91.83%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	82.88%	81.02%	↓	82.82%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	83.93%	83.01%	↓	83.89%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	79.56%	77.77%	↓	79.45%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	48.66%	45.50%	↔	60.05%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	43.31%	45.50%	↔	46.25%
Comprehensive Diabetes Care—HbA1c Testing	80.78%	84.67%	↔	83.54%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	38.20%	50.12%	↑	41.65%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.25%	39.42%	↔	36.08%
Comprehensive Diabetes Care—LDL-C Screening	79.32%	82.97%	↔	80.15%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.05%	88.56%	↑	84.99%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	51.82%	42.34%	▲	47.46%

Table B.74—2014 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
294.71	32.50	421.46	57.87

Table B.75—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population
Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.46%	16.27%	▼	14.03%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.84%	89.83%	↑	87.83%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	95.00%	Not Comparable	95.56%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.00%	89.26%	↑	86.60%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	92.80%	NA	Not Comparable	92.67%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	85.22%	78.45%	↓	85.02%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.22%	83.40%	↔	85.15%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.03%	76.02%	↓	83.63%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	54.97%	49.34%	↔	59.60%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	42.16%	45.13%	↔	50.99%
Comprehensive Diabetes Care—HbA1c Testing	79.69%	78.76%	↔	82.56%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	34.88%	40.71%	↔	38.19%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	30.91%	35.62%	↔	34.00%
Comprehensive Diabetes Care—LDL-C Screening	76.82%	78.32%	↔	79.69%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.38%	82.96%	↑	81.90%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	54.53%	48.23%	↔	48.79%

Table B.76—2014 Non-SPD and SPD Rates for Ambulatory Care Measures
Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino Counties

Non-SPD Visits/1,000 Member Months**		SPD Visits/1,000 Member Months**	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
192.15	35.41	312.01	72.83

Table B.77—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.34%	15.39%	▼	13.71%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	77.06%	80.05%	↔	79.52%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	83.87%	Not Comparable	82.86%
Annual Monitoring for Patients on Persistent Medications—Diuretics	75.81%	80.25%	↔	79.48%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.72%	NA	Not Comparable	94.51%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.98%	80.95%	↔	83.89%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	83.01%	79.07%	↔	82.85%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	81.09%	74.85%	↓	80.58%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	42.49%	51.66%	↑	52.76%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	44.02%	50.33%	↔	48.79%
Comprehensive Diabetes Care—HbA1c Testing	74.81%	76.82%	↔	79.25%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	39.44%	45.92%	↔	45.25%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	28.75%	33.11%	↔	34.44%
Comprehensive Diabetes Care—LDL-C Screening	68.70%	73.73%	↔	75.28%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	72.77%	81.90%	↑	79.47%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	50.89%	44.59%	↔	46.36%

Table B.78—2014 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
204.58	44.36	423.73	68.46

Table B.79—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.52%	17.07%	▼	14.93%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.81%	87.49%	↑	86.03%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	80.36%	Not Comparable	79.66%
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.50%	88.57%	↑	87.07%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.85%	NA	Not Comparable	95.73%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.86%	86.83%	↔	88.81%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	89.22%	84.92%	↓	89.06%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	86.40%	81.87%	↓	86.20%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	55.85%	53.86%	↔	60.71%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	43.27%	56.73%	↑	55.63%
Comprehensive Diabetes Care—HbA1c Testing	82.78%	88.08%	↑	87.64%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	45.03%	52.54%	↑	49.45%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.22%	43.05%	↑	40.18%
Comprehensive Diabetes Care—LDL-C Screening	76.38%	83.00%	↑	82.12%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.38%	88.30%	↑	84.99%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	47.02%	39.51%	▲	41.50%

Table B.80—2014 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
197.22	35.84	434.68	71.93

Table B.81—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	17.72%	↔	16.45%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.76%	85.42%	↔	84.90%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.09%	88.65%	↔	87.77%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	99.10%	NA	Not Comparable	99.10%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.78%	83.93%	↔	90.64%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	87.41%	84.15%	↔	87.25%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	85.57%	68.29%	↓	84.18%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	74.70%	68.39%	↔	70.29%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	49.40%	49.74%	↔	49.64%
Comprehensive Diabetes Care—HbA1c Testing	84.34%	90.67%	↔	88.77%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	44.58%	50.78%	↔	48.91%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	30.12%	44.56%	↑	40.22%
Comprehensive Diabetes Care—LDL-C Screening	73.49%	77.72%	↔	76.45%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.11%	86.53%	↔	83.70%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	45.78%	43.01%	↔	43.84%

Table B.82—2014 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
308.78	40.32	538.03	61.72

Table B.83—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	S	13.24%	↔	11.46%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.58%	83.17%	↔	82.37%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.46%	81.52%	↔	80.80%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.78%	NA	Not Comparable	95.80%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.55%	92.98%	↔	88.64%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.58%	87.01%	↔	88.51%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	88.52%	85.82%	↔	88.35%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.44%	64.73%	↔	63.74%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	31.47%	45.35%	↑	39.34%
Comprehensive Diabetes Care—HbA1c Testing	81.73%	83.33%	↔	82.64%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	35.53%	45.74%	↑	41.32%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	23.86%	33.33%	↑	29.23%
Comprehensive Diabetes Care—LDL-C Screening	62.44%	68.22%	↔	65.71%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	67.51%	81.01%	↑	75.16%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	54.82%	45.74%	↔	49.67%

Table B.84—2014 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
267.41	50.11	586.07	95.80

Table B.85—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.48%	16.98%	▼	15.60%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.91%	90.49%	↑	89.71%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	94.90%	Not Comparable	94.44%
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.24%	90.39%	↑	89.42%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.88%	92.31%	↔	96.81%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.88%	85.68%	↔	87.79%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.88%	85.27%	↔	85.84%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	84.15%	81.25%	↓	83.80%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	69.83%	61.07%	↓	65.21%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.85%	62.04%	↑	60.34%
Comprehensive Diabetes Care—HbA1c Testing	82.24%	83.45%	↔	82.48%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	47.93%	54.50%	↔	52.31%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.98%	48.91%	↑	46.96%
Comprehensive Diabetes Care—LDL-C Screening	75.43%	78.10%	↔	77.86%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	81.27%	89.54%	↑	86.86%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.61%	35.28%	↔	37.47%

Table B.86—2014 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
240.94	45.79	565.93	81.68

Table B.87—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.54%	14.00%	↔	12.79%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.70%	85.94%	↑	84.41%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	87.88%	Not Comparable	88.89%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.87%	86.11%	↔	85.05%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.27%	NA	Not Comparable	98.23%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.28%	91.75%	↔	90.32%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	87.13%	89.15%	↔	87.25%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	86.68%	87.34%	↔	86.73%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	78.80%	66.42%	↓	70.56%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.61%	59.37%	↔	60.10%
Comprehensive Diabetes Care—HbA1c Testing	91.58%	87.59%	↔	89.05%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	50.82%	54.01%	↔	52.55%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	40.49%	41.61%	↔	41.12%
Comprehensive Diabetes Care—LDL-C Screening	80.16%	78.10%	↔	79.81%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.80%	83.45%	↔	82.24%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	36.14%	36.25%	↔	34.55%

Table B.88—2014 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
319.83	34.76	597.96	72.33

Table B.89—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	5.69%	17.88%	▼	13.86%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.25%	87.62%	↔	87.32%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	95.12%	Not Comparable	95.92%
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.72%	86.98%	↔	86.31%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.04%	NA	Not Comparable	97.01%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	92.69%	83.33%	↓	92.55%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	94.85%	89.41%	↓	94.70%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	91.16%	86.96%	↓	91.04%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	76.80%	69.91%	↓	76.57%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	69.14%	62.27%	↓	62.41%
Comprehensive Diabetes Care—HbA1c Testing	88.63%	88.43%	↔	89.33%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	66.13%	65.05%	↔	63.57%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	51.04%	47.92%	↔	47.80%
Comprehensive Diabetes Care—LDL-C Screening	80.51%	78.24%	↔	79.35%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.38%	85.42%	↔	86.77%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	22.27%	23.84%	↔	24.36%

Table B.90—2014 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
330.07	23.26	615.01	75.73

Table B.91—2014 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)
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.29%	18.25%	▼	15.20%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.83%	89.10%	↑	87.39%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	88.61%	Not Comparable	89.01%
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.68%	90.26%	↑	87.91%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	97.31%	80.95%	↓	97.15%
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.94%	88.93%	↔	88.94%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.52%	88.55%	↔	90.46%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.49%	86.53%	↔	87.46%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58.64%	51.09%	↓	56.69%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.45%	44.53%	↔	46.72%
Comprehensive Diabetes Care—HbA1c Testing	80.29%	86.86%	↑	86.86%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.42%	56.45%	↑	54.01%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	36.74%	49.15%	↑	41.36%
Comprehensive Diabetes Care—LDL-C Screening	72.75%	80.29%	↑	81.02%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	77.86%	87.35%	↑	83.45%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	40.63%	34.06%	↔	33.82%

Table B.92—2014 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
240.37	30.95	411.17	45.66

APPENDIX C. INDIVIDUAL MANAGED CARE HEALTH 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: The statewide collaborative *ACR* QIP did not progress to the Outcomes stage during the measurement period; therefore, HSAG includes no outcome information for this QIP. Additionally, HSAG includes no outcomes table for the following MCPs because their internal QIPs did not progress to the Outcomes stage:

- AIDS Healthcare Foundation
  - *CD4 and Viral Load Testing (Open)*
  - *Reducing Avoidable Emergency Department Visits*
- Anthem Blue Cross Partnership Plan
  - *Childhood Immunization Status*
  - *Improving Diabetes Management (Closed)*
  - *Improving Diabetes Management (Open)*
  - *Improving Timeliness of Prenatal and Postpartum Care*
- CalViva Health
- CenCal Health

- Central California Alliance for Health
- Community Health Group Partnership Plan
- Contra Costa Health Plan
- Family Mosaic Project
- Gold Coast Health Plan
- Kaiser North
- San Francisco Health Plan

Table C.1—Quality Improvement Project Domain(s) of Care and Interventions
AIDS Healthcare Foundation—Los Angeles County
July 1, 2013, through June 30, 2014

QIP #1—Advance Care Directives		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Nonclinical	Q	◆ Provided a bi-monthly advance care directive member education class that explained what an advance care directive is, its importance, and how it works. The MCP also provided an opportunity for members to complete the Five Wishes advance directive during the class. ◆ Implemented the advance directive prompt which included electronic health record advance care directive encounter inclusion in internal protocol/audit system and medical visit flow sheets. ◆ Provided an annual member newsletter that discussed the importance of completing an advance directive and provided available resources to assist members in completing an advance directive. ◆ Produced an annual provider newsletter with information on the importance of completing an advance directive and listed the resources available to members. ◆ Provided a quarterly report card indicating the providers' rates for advance care directive completion and/or discussion of advance care directives. ◆ Nurse managers and referral coordinators detailed their roles in uploading electronic versions of advance directives into electronic medical records. ◆ Educated providers on the importance of all people living with HIV having a complete advance directive.
QIP #2—CD4 and Viral Load Testing (Closed)		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Provider Education ◆ Member Education ◆ Reminder System ◆ Care Manager Outreach ◆ Health Promotion Media Campaign
QIP #3—CD4 and Viral Load Testing (Open)		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.
QIP #4—Reducing Avoidable Emergency Department Visits		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.

Table C.2—Quality Improvement Project Validation Activity
AIDS Healthcare Foundation—Los Angeles County
July 1, 2013, through June 30, 2014

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 (Closed)	Annual Submission	81%	100%	*Met*
CD4 and Viral Load Testing (Open)	Study Design Submission	91%	100%	*Met*
Reducing Avoidable Emergency Room Visits	Study Design Submission	73%	40%	*Partially 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.3—Quality Improvement Project Average Rates*
AIDS Healthcare Foundation—Los Angeles County
(Number = 5 QIP Submissions, 3 QIP Topics)
July 1, 2013, through June 30, 2014

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)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	87%	13%	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	95%	5%	0%
Design Total		**93%**	**7%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	88%	6%	6%
	VIII: Appropriate Improvement Strategies	86%	14%	0%
Implementation Total		**87%**	**9%**	**4%**
Outcomes	IX: Real Improvement Achieved**	50%	13%	38%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total**		**56%**	**11%**	**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.

**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, 2013, through June 30, 2014

QIP #1—Advance Care Directives			
Study Indicator: Percentage of eligible members who have an advance directive or have had a discussion regarding advance 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%*	29.9%	Yes

QIP #2—CD4 and Viral Load Testing (Closed)				
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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
69.3%	69.7%	63.8%	64.9%	‡
Study Indicator 2: Percentage of eligible members receiving at least three viral load 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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
68.9%	73.4%	65.7%**	62.9%	‡

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

***** Statistically significant improvement over baseline (*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.5—Quality Improvement Project Domain(s) of Care and Interventions
Alameda Alliance for Health—Alameda County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ The Mobile Medical Examination Service conducted home visits. The purpose of the home visit was to: ▪ Assess and compile clinical and diagnostic data from the member for the purposes of care coordination, disease management, and education. ▪ Provide members with guidance related to specific issues to discuss with the primary care physician. ▪ Identify urgent health problems or health risks. ▪ Optimize the Centers for Medicare & Medicaid Services Hierarchical Condition Categories scoring through appropriate documentation of medical records and submission of all relevant ICD-9 diagnostic codes identified during the home visit. ▪ Follow up with members who were readmitted to assess the cause and effect of the readmission.
QIP #2—Improving Anti-Hypertensive Medication Fills Among Members with Hypertension		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Continued to share information with providers about the *Controlling High Blood Pressure* measure, and submitted a report to providers about their patients who have hypertension but no hypertension medications (to encourage improving hypertensive prescriptions). ◆ Continued to encourage antihypertensive medication adherence among hypertensive members by providing targeted outreach through case management and disease management as well as reminder letters and tools that empower members to take their medications. ◆ Conducted outreach programs through interactive voice response (IVR) calls, case and disease management, and medication adherence reminder letters.

Table C.6—Quality Improvement Project Validation Activity
Alameda Alliance for Health—Alameda County
July 1, 2013, through June 30, 2014

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	Annual Submission	63%	86%	*Partially Met*
	Annual Resubmission 1	63%	86%	*Partially Met*
	Annual Resubmission 2	69%	86%	*Partially Met*
	Annual Resubmission 3	100%	100%	*Met*
Internal QIPs				
Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension	Annual Submission	54%	57%	*Not Met*
	Annual Resubmission 1	62%	71%	*Partially Met*
	Annual Resubmission 2	62%	71%	*Partially Met*
	Annual Resubmission 3	77%	86%	*Partially Met*
	Annual Resubmission 4	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.7—Quality Improvement Project Average Rates*
Alameda Alliance for Health—Alameda County
(Number = 9 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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)	89%	11%	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**	89%	6%	6%
Design Total		**95%**	**3%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	48%	21%	30%
	VIII: Appropriate Improvement Strategies	57%	43%	0%
Implementation Total**		**51%**	**28%**	**22%**
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.

Table C.8—Quality Improvement Project Outcomes
Alameda Alliance for Health—Alameda County
July 1, 2013, through June 30, 2014

QIP #1—Improving Anti-Hypertensive Medication Fills Among Members with Hypertension			
Study Indicator 1: The percentage of members 18–85 years of age continuously enrolled as of December 31 of each measurement year, with a diagnosis of hypertension in the first 6 months of the measurement year who filled at least one anti-hypertensive medication.			
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¥**
65.6%	64.0%	‡	‡
Study Indicator 2: The percentage of members 18–85 years of age continuously enrolled as of December 31 of each measurement year, with a diagnosis of hypertension in the first 6 months of the measurement year and taking at least 1, 2, or 3 antihypertensive medications who had a fill rate of at least 40% during the measurement year.			
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¥**
53.9%	48.3%*	‡	‡

¥ 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 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.9—Quality Improvement Project Domain(s) of Care and Interventions
Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, Tulare	Q, A	◆ Implemented a formal process to facilitate a safe discharge and/or transition of care for members. ◆ Provided education and counseling for members and families to enhance active participation in their own care. ◆ Discharge planners assessed the member's family dynamics prior to discharge to identify potential family or financial issues.
QIP #2—Childhood Immunization Status			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Sacramento	Q, A, T	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.
QIP #3—Improving Diabetes Management (Closed)			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Alameda, Contra Costa, Fresno, Kings, Madera	Q, A	◆ Provided members who received three diabetic tests (HbA1c, LDL, and nephropathy) a $25 incentive and members who received their diabetic retinal eye exam a $25 incentive. ◆ Performed outbound calls to members who were noncompliant for one or more diabetic screenings between January and August and live calls to members to reinforce incentive offerings from September to December. ◆ Distributed and assisted provider groups in the use of gap-in-care projects.

QIP #4—Improving Diabetes Management (Open)			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Alameda, Contra Costa, Fresno, Kings, Sacramento, San Francisco, Tulare	Q, A	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.
QIP #5—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, T	◆ Distributed prenatal education packet. ◆ Sent out reminder mailings. ◆ Performed reminder calls. ◆ Implemented member incentive gift cards. ◆ Worked with high-risk members in case management. ◆ Promoted the perinatal guidelines. ◆ Distributed provider toolkits. ◆ Distributed transportation information.
QIP #6—Improving Timeliness of Prenatal and Postpartum Care			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, Tulare	Q, A, T	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.

*Anthem stopped providing MCMC services in San Joaquin and Stanislaus counties on December 31, 2012; however, since the QIP submission reported calendar year 2012 results, these counties were included in the QIP submission information.

Table C.10—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, 2013, through June 30, 2014

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	All counties—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, and Tulare—received the same score.	Annual Submission	81%	100%	*Met*
Internal QIPs					
Childhood Immunization Status	Sacramento	Study Design Submission	88%	71%	*Not Met*
		Study Design Resubmission 1	100%	100%	*Met*
Improving Diabetes Management (Closed)	Alameda and Contra Costa counties received the same score.	Annual Submission	84%	90%	*Partially Met*
		Annual Resubmission 1	96%	90%	*Partially Met*
	Fresno, Kings, and Madera counties received the same score.	Annual Submission	80%	80%	*Partially Met*
		Annual Resubmission 1	96%	90%	*Partially Met*
Improving Diabetes Management (Open)	All counties—Alameda, Contra Costa, Fresno, Kings, Sacramento, San Francisco, and Tulare—received the same score.	Study Design Submission	94%	86%	*Not Met*
		Study Design Resubmission 1	100%	100%	*Met*
Improving HEDIS Postpartum Care Rates	Sacramento	Annual Submission	85%	90%	*Partially Met*
	San Francisco	Annual Submission	83%	90%	*Partially Met*
	San Joaquin*	Annual Submission	57%	70%	*Not Met*
	Santa Clara	Annual Submission	86%	90%	*Partially Met*
	Stanislaus*	Annual Submission	57%	70%	*Not Met*
	Tulare	Annual Submission	89%	90%	*Partially Met*

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]
Improving Timeliness of Prenatal and Postpartum Care	All counties—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, and Tulare—received the same score.	Study Design Submission	94%	86%	*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*.

*Anthem stopped providing MCMC services in San Joaquin and Stanislaus counties on December 31, 2012; however, since the QIP submission reported calendar year 2012 results, these counties were included in the QIP submission information.

Table C.11—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 = 57 QIP Submissions, 6 QIP Topics)
July 1, 2013, through June 30, 2014

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	97%	3%	0%
	II: Clearly Defined, Answerable Study Question(s)	98%	2%	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)	98%	0%	2%
	VI: Accurate/Complete Data Collection	88%	6%	6%
Design Total**		**95%**	**2%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	77%	0%	23%
	VIII: Appropriate Improvement Strategies	48%	45%	7%
Implementation Total**		**69%**	**14%**	**18%**
Outcomes	IX: Real Improvement Achieved**	38%	0%	63%
	X: Sustained Improvement Achieved	50%	0%	50%
Outcomes Total**		**38%**	**0%**	**62%**

*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.12—Quality Improvement Project Outcomes for Anthem Blue Cross Partnership Plan—Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties July 1, 2013, through June 30, 2014

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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
Sacramento	52.1%	49.9%	54.3%	47.9%	‡
San Francisco	57.4%	55.5%	64.0%	64.8%	‡
San Joaquin	48.9%	51.3%	48.2%	***	‡
Santa Clara	55.5%	65.7%*	60.6%	56.5%	No
Stanislaus	54.3%	53.7%	56.7%	***	‡
Tulare	46.5%	64.0%*	53.1%**	56.2%	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.

***** Statistically significant improvement over baseline (p value < 0.05).

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

******* Although Anthem was providing MCMC services in San Joaquin and Stanislaus counties during the reporting period for this QIP, the MCP did not report rates for these counties in the QIP submission.

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

Table C.13—Quality Improvement Project Domain(s) of Care and Interventions
CalOptima—Orange County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Implemented a transitional care model program based on Eric Coleman's Care Transitions Intervention Program. Members in the target population were invited to participate in the no-cost program which included a home visit, follow-up calls, and possible referrals. Members who declined a home visit were offered coaching via telephone. ◆ Members who declined participation in the transitions of care program were sent a discharge kit that included a personal health record, medication lists, a medication pillbox, health education material, and resources.
QIP #2—Improvement of Prenatal Visit Rates for Pregnant Members		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A, T	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.
QIP #3—Improving the Rates of Cervical Cancer Screening		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q	◆ Mailed remainder letters and brochures to eligible members. ◆ Implemented a telephonic outreach program to eligible members. ◆ Mailed lists of assigned members needing screening to providers and followed the mailing with in-person reinforcement by the provider office education manager.

Table C.14—Quality Improvement Project Validation Activity
CalOptima—Orange County
July 1, 2013, through June 30, 2014

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	Annual Submission	94%	100%	*Met*
Internal QIPs				
Improvement of Prenatal Visit Rates for Pregnant Members	Study Design Submission	56%	29%	*Not Met*
	Study Design Resubmission 1	100%	100%	*Met*
Improving the Rates of Cervical Cancer Screening	Annual Submission	82%	90%	*Partially 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.15—Quality Improvement Project Average Rates*
CalOptima—Orange County
(Number = 4 QIP Submissions, 3 QIP Topics)
July 1, 2013, through June 30, 2014

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)	75%	25%	0%
	III: Clearly Defined Study Indicator(s)	78%	22%	0%
	IV: Correctly Identified Study Population	75%	25%	0%
	V: Valid Sampling Techniques (if sampling is used)	94%	6%	0%
	VI: Accurate/Complete Data Collection**	86%	5%	10%
Design Total		**88%**	**9%**	**3%**
Implementation	VII: Sufficient Data Analysis and Interpretation	85%	0%	15%
	VIII: Appropriate Improvement Strategies	60%	40%	0%
Implementation Total		**78%**	**11%**	**11%**
Outcomes	IX: Real Improvement Achieved	25%	75%	0%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**25%**	**75%**	**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.16—Quality Improvement Project Outcomes for CalOptima—Orange County
July 1, 2013, through June 30, 2014

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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
71.7%	75.5%	72.0%	75.1%	‡
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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
69.6%	71.0%*	71.1%	71.0%	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.

* Statistically significant improvement over baseline (p value < 0.05).

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

Table C.17—Quality Improvement Project Domain(s) of Care and Interventions
CalViva Health—Fresno, Kings, and Madera Counties
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Implemented a transitional care model program using the Coleman Care Transitions Intervention as the underlying foundation. ◆ Implemented an ambulatory case management program to focus on transition of care and continuity of care. ◆ Made interactive voice response (IVR) calls to members hospitalized for any condition to encourage them to call their providers and/or the Nurse Advice Line for any questions about their care and to set up follow-up appointments with their primary care providers. ◆ Placed on-site case managers at high-volume hospitals. ◆ Provided the Agency for Healthcare Research and Quality (AHRQ) *Taking Care of Myself Guide* to hospitals and providers to distribute to patients prior to discharge. ◆ Expanded the disease management program and education to include other chronic conditions.
QIP #2—Retinal Eye Exams		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ The MCP's medical management team visited each clinic and conducted a presentation outlining the project goals, barriers identified to date, clinic-specific rates, documentation requirements, recommendations for improvement, and plans for remeasurement. ◆ Compared the quarterly provider profile of noncompliant cases with a claims report to evaluate improvements in both clinical procedures and billing procedures, and shared this information with the clinics. ◆ Audited 10 percent of eligible members per clinic quarterly to concurrently evaluate the complete process, including exam results in the clinic record and compliance with overall improvement strategy implementation. ◆ Distributed an educational flyer to communicate the importance of an annual retinal eye exam and the process for obtaining the exam. ◆ Included an article on retinal eye exams for members with diabetes in the MCP's spring 2014 newsletter.

Table C.18—Quality Improvement Project Validation Activity
CalViva Health—Fresno, Kings, and Madera Counties
July 1, 2013, through June 30, 2014

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	All counties received the same score	Annual Submission	100%	100%	*Met*
Internal QIPs					
Retinal Eye Exams	Fresno	Annual Submission	72%	80%	*Not Met*
		Annual Resubmission 1	100%	100%	*Met*
	Kings	Annual Submission	76%	80%	*Not Met*
		Annual Resubmission 1	100%	100%	*Met*
	Madera	Annual Submission	76%	80%	*Not 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.19—Quality Improvement Project Average Rates*
CalViva Health—Fresno, Kings, and Madera Counties
(Number = 9 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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)	89%	3%	8%
	VI: Accurate/Complete Data Collection	94%	0%	6%
Design Total		**95%**	**1%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	79%	7%	14%
	VIII: Appropriate Improvement Strategies	83%	17%	0%
Implementation Total		**80%**	**10%**	**10%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**

*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.20—Quality Improvement Project Domain(s) of Care and Interventions
Care1st Partner Plan—San Diego County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Discharge Planning: ▪ Select hospitals had on-site hospitalist and in-house case management. ▪ Case management and discharge planning began when the member was admitted to any of the select hospitals. ▪ Case manager was assigned, social services goals were set, and a plan was developed to assess triggers for readmission. ▪ Ensured that all members being discharged have a follow-up appointment with their PCP or specialist scheduled within seven days of discharge. ▪ Ensured that full medication reconciliation is completed with the PCP within seven days of discharge. ◆ Assured Members Followed Up with PCP: ▪ Case manager or coordinator placed a reminder call to the member the day prior to the scheduled PCP or specialist follow-up appointment. ▪ Follow-up call was made to member after the PCP or specialist visit to confirm the member was seen and, if not, the appointment was rescheduled. ▪ Free transportation was arranged for members as needed.

QIP #2—Comprehensive Diabetic Care		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Identified members who were not controlled or who were still in need of diabetes preventive services by using the following interventions: ▪ Mailed educational materials semiannually to the members. ▪ Developed a proactive outreach program that focused on placing follow-up calls; sending medication adherence postcards; using case managers, pharmacists, or clinical educators to remind members of the importance of taking insulin and educating them

QIP #2—Comprehensive Diabetic Care		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
		on medication adherence; and identifying members in need of transportation services. ◆ Assigned a dedicated project manager to focus on quality improvement projects. ◆ Developed a methodology to identify the top 10 high-volume, low-performing providers. Once these providers were identified, implemented high-touch interventions including the following: ▪ Conducted face-to-face visits. ▪ Provided educational materials and seminars on-site at provider offices or via webinar that focused on treatment protocols, management of short- and long-term complications, ways to develop the care plan, and efficient use of clinic staff. ▪ Reviewed medical records for accuracy. ▪ Expedited specialty care referrals for endocrinology, ophthalmology, podiatry, nephrology, and neurology. ▪ Made direct member referrals to an endocrinologist. ▪ Provided templates of care plans to the providers. ◆ Worked with labs and vision service providers to get more real-time data. ◆ Relaunched the MCP's provider incentive program.

Table C.21—Quality Improvement Project Validation Activity
Care1st Partner Plan—San Diego County
July 1, 2013, through June 30, 2014

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	Annual Submission	56%	57%	*Not Met*
	Annual Resubmission 1	63%	57%	*Partially Met*
	Annual Resubmission 2	94%	100%	*Met*
Internal QIPs				
Comprehensive Diabetic Care	Annual Submission	74%	90%	*Partially Met*
	Annual Resubmission 1	85%	90%	*Partially Met*
	Annual Resubmission 2	85%	90%	*Partially Met*
	Annual 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.22—Quality Improvement Project Average Rates*
Care1st Partner Plan—San Diego County
(Number = 7 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	86%	7%	7%
	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%	13%	0%
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		**95%**	**4%**	**1%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	73%	13%	15%
	VIII: Appropriate Improvement Strategies	67%	33%	0%
Implementation Total		**71%**	**18%**	**11%**
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.

Table C.23—Quality Improvement Project Outcomes
Care1st Partner Plan—San Diego County
July 1, 2013, through June 30, 2014

QIP #1—Comprehensive Diabetic Care			
Study Indicator 1: The percentage of diabetic members 18–75 years of age who received at least one 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¥**
83.6%	88.8%	84.9%	‡
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%	42.1%	‡
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%	78.6%	‡
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%	40.4%	‡
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%	85.4%	‡

^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.24—Quality Improvement Project Domain(s) of Care and Interventions
CenCal Health—San Luis Obispo and Santa Barbara Counties
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Implemented a primary care physician (PCP) incentive payment process to reimburse providers for the extra time needed to accommodate access to timely (within 72 hours) appointments for discharged members. ◆ Developed intradepartmental collaboration to facilitate PCP appointment scheduling for members requiring assistance, letter notification for members unable to be reached by telephone, provider services promotion and training of PCPs, and claims reports and payments. ◆ Established readmissions agreement with a large federally qualified health center (FQHC) PCP clinic system to perform outreach to its members, and provided an incentive to the clinic for reducing its readmissions rates. ◆ Developed a fax/email process to notify PCPs within 24 hours of their members being discharged from hospitals so the PCPs can perform outreach and increase access to timely appointments. Discharge summaries were provided to PCPs as part of this process. ◆ Conducted weekly utilization management/case management departmental meetings to discuss high-risk cases and monthly utilization management/case management metrics meetings to discuss readmissions rates, community-based resources, and resource voids (e.g., being homeless, lacking mental health services). ◆ Hired a full-time health services representative to work with community providers and external agencies on behalf of CenCal in matters pertaining to high-risk members. The staff member was based primarily at a high-volume, mid-county hospital. ◆ Refined the process to identify members discharged from in- and out-of-area hospitals and to monitor cases using case management software.

QIP #2—Annual Monitoring for Patients on Persistent Medications		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q	◆ Interventions targeting providers included: ▪ Provided annual performance profiles to the providers based on HEDIS results. The MCP performed on-site visits for high-volume, low-performing providers and called or mailed a summary to low-volume or high-performing clinics. ▪ Published a provider bulletin article regarding the importance of monitoring patients on persistent medications. ▪ Mailed the providers a list of eligible members who did not receive the required tests. ◆ Interventions targeting members included: ▪ Implemented member outreach program including mailing eligible members informational flyers. ▪ Published a newsletter outlining the same information from the targeted mailing.

Table C.25—Quality Improvement Project Validation Activity
CenCal Health—San Luis Obispo and Santa Barbara Counties
July 1, 2013, through June 30, 2014

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	Both counties received the same score	Annual Submission	88%	86%	*Partially Met*
		Annual Resubmission 1	100%	100%	*Met*
Internal QIPs					
Annual Monitoring for Patients on Persistent Medications	Both counties received the same score	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.26—Quality Improvement Project Average Rates*
CenCal Health—San Luis Obispo and Santa Barbara Counties
(Number = 6 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	83%	8%	8%
	VIII: Appropriate Improvement Strategies	83%	17%	0%
Implementation Total		**83%**	**11%**	**6%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**

*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.27—Quality Improvement Project Domain(s) of Care and Interventions
Central California Alliance for Health—Merced and Monterey/Santa Cruz Counties
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	**Alliance Telephonic Care Transitions Program** ◆ Conducted telephonic assessment post-discharge with all members in Santa Cruz and Merced counties who had a diagnosis of heart failure, myocardial infarction, diabetes, asthma, or pneumonia. The call included verification of a primary care physician (PCP) follow-up appointment within 14 days after discharge, medication inventory, an advance care plan, and a member satisfaction survey. ▪ A second telephone call was made after the 14-day follow-up appointment to conduct a medication inventory and assess for any additional needs. **Alliance Home Visit Care Transitions Pilot Program** ◆ Readmitted members discharged from Monterey County hospitals with a diagnosis of heart failure, myocardial infarction, diabetes, asthma, or pneumonia were visited by a Visiting Nurse Association (VNA) nurse within 72 hours of the hospital discharge. The nurse verified that the member had a follow-up visit scheduled with his/her PCP within 14 days of the discharge, completed a medication reconciliation, completed an advance care plan, and conducted a member satisfaction survey. ◆ Conducted a second VNA visit after the PCP visit to perform second medication reconciliation and assessed for any additional needs. ◆ Implemented a process to send a fax to the PCP when a member has an inpatient admission. The fax included the member's 90-day readmission history and a reminder that the member will need a follow-up appointment within 14 days.

QIP #2—Improving Asthma Health Outcomes		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Redesigned the asthma action plan (AAP) template into an electronic and paper form. The forms were used by providers to help guide discussions with members regarding their asthma condition. The forms included the following: ▪ A place for member and/or parent to sign an attestation acknowledging understanding of what to do to keep asthma symptoms under control. ▪ A place for member to indicate to the provider the severity of his/her asthma. If the member has persistent asthma and the

QIP #2—Improving Asthma Health Outcomes		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
		provider does not complete the form correctly, the MCP will contact the provider to review how to correctly complete the form. ▪ A place for the member to indicate what triggers his/her asthma. ◆ Enhanced the MCP's current Healthy Breathing for Life (HBL) monthly report. ◆ Revised the HBL identification criteria to match HEDIS/NCQA identification criteria. ◆ Established asthma health education in Merced County. ◆ For Monterey County providers, generated provider-specific reports on *Medication Management for People with Asthma* rate, ED use, hospital admissions, and AAP submission rate. ◆ Administered educational outreach programs for members admitted to the hospital for asthma. ◆ Performed process improvements including health educators approving AAPs in workflow and providing both provider and member newsletters regarding improved asthma management and utilization for asthma health education benefit.

Table C.28—Quality Improvement Project Validation Activity
Central California Alliance for Health—Merced and Monterey/Santa Cruz Counties
July 1, 2013, through June 30, 2014

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	All counties received the same score	Annual Submission	94%	100%	*Met*
Internal QIPs					
Improving Asthma Health Outcomes	All counties received the same score	Annual Submission	88%	86%	*Partially Met*
	All counties received the same score	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.29—Quality Improvement Project Average Rates*
Central California Alliance for Health—Merced and Santa Cruz/Monterey Counties
(Number = 6 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	75%	8%	17%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**83%**	**6%**	**11%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**

*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.30—Quality Improvement Project Domain(s) of Care and Interventions
Community Health Group Partnership Plan—San Diego County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ A local pharmacy delivered the medications to the member immediately after discharge or while the member was still at the hospital. ◆ A home health nurse visited the member within one day of discharge to review post-discharge instructions/medications. ◆ A complex case management case manager contacted the member to facilitate follow-up with the member's PCP. ◆ The MCP provided non-covered services intended to have a positive impact on a member's condition or to prevent the worsening of an existing condition. ◆ Case managers conducted home visits to engage the member and complete a form to obtain basic information about the member and to assist in coordinating follow-up care post-discharge.
QIP #2—Increasing Screening for Postpartum Depression		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A, T	◆ Called new mothers to reminder them of postpartum visits. ◆ Sent post-delivery congratulatory and educational letter for each live birth. ◆ Provided members with a $25 incentive gift card for completing the postpartum visit during the required time frame. ◆ Contacted providers who bill for global delivery charges to obtain the specific dates of the postpartum visits. ◆ Assisted members who have delivered with scheduling their postpartum visits 21 to 56 days after delivery, and provided taxi transportation to and from the visits. ◆ Contracted with a home care vendor who provided nurse practitioners to conduct postpartum visits, and offered an in-home postpartum visit to members who had not completed a visit. ◆ Obtained the member's hospital face sheet to compare the most current demographic data with data in the member profile, and updated the information if necessary.

Table C.31—Quality Improvement Project Validation Activity
Community Health Group Partnership Plan—San Diego County
July 1, 2013, through June 30, 2014

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	Annual Submission	75%	71%	*Partially Met*
	Annual Resubmission 1	94%	86%	*Partially Met*
	Annual Resubmission 2	100%	100%	*Met*
Internal QIPs				
Increasing Postpartum Care Visits within 6 Weeks of Delivery	Study Design Submission	67%	71%	*Not Met*
	Study Design Resubmission 1	100%	100%	*Met*
	Annual Submission	76%	80%	*Partially Met*
	Annual Resubmission 1	96%	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 = 7 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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%	13%	0%
	VI: Accurate/Complete Data Collection**	92%	6%	3%
Design Total		**94%**	**5%**	**1%**
Implementation	VII: Sufficient Data Analysis and Interpretation	64%	27%	9%
	VIII: Appropriate Improvement Strategies	60%	40%	0%
Implementation Total		**63%**	**31%**	**6%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**

*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.33—Quality Improvement Project Domain(s) of Care and Interventions
Contra Costa Health Plan—Contra Costa County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Established a call center with a nurse available during weekdays to assist discharge staff at area hospitals with ensuring that all required services and follow-up care were arranged before the member was discharged. ◆ Had a nurse call members post-discharge from the county hospital to ensure that all care needs were met. ◆ Implemented a new initiative to provide a family nurse practitioner to visit members in skilled nursing facilities and to be available to skilled nursing facilities when a potential need to prevent a readmission was identified.
QIP #2—Improving Perinatal Access and Care		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A, T	◆ Worked with outside hospitals to set up a process to schedule appropriately timed postpartum appointments prior to discharge. ◆ Developed a system to call new mothers to ensure appointments are scheduled and remind them of their appointments. ◆ Worked with Contra Costa Regional Medical Center to develop a system that ensures providers will address the requirements of a postpartum visit. ◆ Worked with its largest provider network to improve the provision of contraception.

Table C.34—Quality Improvement Project Validation Activity
Contra Costa Health Plan—Contra Costa County
July 1, 2013, through June 30, 2014

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	Annual Submission	75%	100%	*Partially Met*
	Annual Resubmission 1	100%	100%	*Met*
Internal QIPs				
Improving Perinatal Access and Care	Study Design Submission	95%	88%	*Partially Met*
	Study Design Resubmission 1	95%	88%	*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.35—Quality Improvement Project Average Rates*
Contra Costa Health Plan—Contra Costa County
(Number = 5 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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	92%	8%	0%
Design Total		**97%**	**3%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	75%	0%	25%
	VIII: Appropriate Improvement Strategies	80%	20%	0%
Implementation Total		**78%**	**11%**	**11%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**

*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.36—Quality Improvement Project Domain(s) of Care and Interventions
Family Mosaic Project—San Francisco County
July 1, 2013, through June 30, 2014

QIP #1—Child and Adolescent Needs and Strengths (CANS) Depression Rating		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.
QIP #2—Increase the Rate of School Attendance (Closed)		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Nonclinical	Q	◆ No intervention information is included for this QIP since the data were not valid.
QIP #3—Increase the Rate of School Attendance (Open)		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q	◆ Referred to the Family Mosaic Project educational evaluator for educational testing of those members identified as having missed school at least two days per week on average, generally truant, or who refused to go to school. ◆ The evaluator assessed the member's academic skills and deficiencies and recommended a specialized or intensive instruction to improve competency. ◆ The evaluator met with the care manager, parent/caregiver, and other providers to identify the member's learning style and develop an individualized education plan.

Table C.37—Quality Improvement Project Validation Activity
Family Mosaic Project—San Francisco County
July 1, 2013, through June 30, 2014

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				
Child and Adolescent Needs and Strengths (CANS) Depression Rating	Study Design Submission	64%	80%	*Partially Met*
	Study Design Resubmission 1	100%	100%	*Met*
Increase the Rate of School Attendance (Closed)	Annual Submission	62%	71%	*Partially Met*
	Annual Resubmission 1	65%	71%	*Partially Met*
Increase the Rate of School Attendance (Open)	Study Design 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.38—Quality Improvement Project Average Rates*
Family Mosaic Project—San Francisco County
(Number = 5 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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)	87%	13%	0%
	IV: Correctly Identified Study Population	80%	20%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	55%	35%	10%
Design Total		**78%**	**18%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	44%	50%	6%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**64%**	**32%**	**4%**
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.39—Quality Improvement Project Domain(s) of Care and Interventions
Gold Coast Health Plan—Ventura County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ MCP staff members called or visited members 24–72 hours after discharge to: ▪ Ensure the members made and kept their follow-up appointment. ▪ Ask if discharge instructions were understood and explain the discharge instructions further. ▪ Ask if the members filled their prescriptions. ▪ Ask how medications were taken to see if members understood and complied. ▪ Send and provide additional educational material if needed or requested. ▪ Provide education in a way that addressed language or educational barriers.
QIP #2—Increasing the Rate of Annual Diabetic Eye Exam		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Sent letters to providers indicating which members with diabetes had completed or were pending diabetic screening tests. ◆ Provided educational materials in both English and Spanish to members with diabetes. ◆ Worked with a claims vendor to provide membership files to providers. ◆ Collected more detailed and complete medical and vision claims data to improve capture of vision services provided to members with diabetes. ◆ Increased members' awareness of available transportation services. ◆ Increased members' awareness of vision coverage.

Table C.40—Quality Improvement Project Validation Activity
Gold Coast Health Plan—Ventura County
July 1, 2013, through June 30, 2014

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	Annual Submission	63%	100%	*Partially Met*
	Annual Resubmission 1	88%	100%	*Met*
Internal QIPs				
Increasing the Rate of Annual Diabetic Eye Exam	Annual Submission	64%	70%	*Partially Met*
	Annual Resubmission 1	92%	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.41—Quality Improvement Project Average Rates*
Gold Coast Health Plan—Ventura County
(Number = 4 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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)**	88%	13%	0%
	IV: Correctly Identified Study Population	75%	25%	0%
	V: Valid Sampling Techniques (if sampling is used)	83%	17%	0%
	VI: Accurate/Complete Data Collection	45%	35%	20%
Design Total		**73%**	**20%**	**7%**
Implementation	VII: Sufficient Data Analysis and Interpretation	83%	6%	11%
	VIII: Appropriate Improvement Strategies**	88%	13%	0%
Implementation Total**		**85%**	**8%**	**8%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**

*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.42—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, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Implemented the Transition of Care Management program. The MCP used an advanced analytics program to identify members at high risk for readmission. The high-risk members were contacted by case managers for assessment of their condition and provision of support and education. ◆ On a weekly basis, the MCP identified members admitted and discharged from a hospital. The members received an Interactive Voice Response (IVR) reminder call advising them to make a follow-up appointment with their primary care physician (PCP) within seven days of discharge and to call their PCP or the Nurse Advice Line for any health care needs or questions. The MCP worked with the IVR vendor to use methods found to be successful with specific populations. ◆ The MCP coordinated a medication adherence program for members diagnosed with hyperlipidemia, hypertension, diabetes, asthma, and chronic obstructive pulmonary disease. Members prescribed medications specific to their conditions but who have not had their prescriptions filled were sent reminder letters to have the prescriptions filled or to call their physicians. Providers of members who continue to not have their prescriptions filled after receiving the reminder letter were notified and encouraged to contact their patients. ◆ The MCP coordinated a program to reconcile medications newly prescribed from the hospital with member's other medications once the member is discharged from the hospital. Instructions to members included medication dosage, frequency, and importance of taking medications as prescribed. ◆ Developed a program to identify primary physician groups (PPGs) with high rates of readmissions and ensured the members with high rates of readmissions from these PPGs received the IVR call and appropriate educational materials. Additionally, notified the PPGs when their patients were discharged to encourage the PPGs to contact the member for a follow-up appointment within seven days of discharge.

QIP #2—Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities (SPD)		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Member education ◆ Member newsletter mailings ◆ Member incentives ◆ Sent letters to providers with a list of members due for a Pap test to encourage them to schedule an appointment with the members. ◆ Educated providers on the new 2014 CCS HEDIS specifications.
QIP #3—Improving Postpartum Care Among Medi-Cal Women Including Seniors and Persons with Disabilities		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A, T	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.

Table C.43—Quality Improvement Project Validation Activity
Health Net Community Solutions, Inc.—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties
July 1, 2013, through June 30, 2014

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	All counties received the same score	Annual Submission	94%	86%	*Partially Met*
		Annual Resubmission 1	100%	100%	*Met*
Internal QIPs					
Improve Cervical Cancer Screening Among Seniors and Persons with Disabilities	All counties received the same score	Annual Submission	69%	86%	*Partially Met*
Improving Postpartum Care Among Medi-Cal Women Including Seniors and Persons with Disabilities	All counties received the same score	Study Design 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.44—Quality Improvement Project Average Rates*
Health Net Community Solutions, Inc.—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties
(Number = 24 QIP Submissions, 3 QIP Topics)
July 1, 2013, through June 30, 2014

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%	6%	0%
	VIII: Appropriate Improvement Strategies**	38%	63%	0%
Implementation Total		**75%**	**25%**	**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.

Table C.45—Quality Improvement Project Outcomes
Health Net Community Solutions, Inc.—Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare Counties
July 1, 2013, through June 30, 2014

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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
Kern	40.9%	41.5%	42.0%	24.9%*	‡
Los Angeles	50.8%	50.5%	49.8%	34.7%*	‡
Sacramento	39.6%	37.4%	39.8%	28.6%*	‡
San Diego	42.1%	43.4%	41.1%	28.4%*	‡
Stanislaus	44.7%	47.9%	45.6%	28.7%*	‡
Tulare	40.6%	46.5%	45.6%	32.3%*	‡

¥ 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.46—Quality Improvement Project Domain(s) of Care and Interventions
Health Plan of San Joaquin—San Joaquin County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Implemented a transitional care behavioral health intervention program that includes a mental health specialist seeing the members while they are in the acute care setting. Additionally, the mental health specialist joined the nurse practitioner on home visits to follow up with recently discharged members. ◆ Implemented a pilot biometric outreach program which allows for in-home monitoring of high-risk members.
QIP #2—Improve the Percentage of HbA1C Testing		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Hired a full-time HEDIS coordinator to help improve processes and rates. ◆ Continued outreach programs and expanded to the Patient Centered Medical Home Program. ◆ Continued outreach and support programs to providers.

Table C.47—Quality Improvement Project Validation Activity
Health Plan of San Joaquin—San Joaquin County
July 1, 2013, through June 30, 2014

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	Annual Submission	75%	86%	*Partially Met*
	Annual Resubmission 1	88%	86%	*Partially Met*
	Annual Resubmission 2	100%	100%	*Met*
Internal QIPs				
Improving the Percentage Rate of HbA1c Testing	Annual Submission	74%	90%	*Partially Met*
	Annual Resubmission 1	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.48—Quality Improvement Project Average Rates*
Health Plan of San Joaquin—San Joaquin County
(Number = 5 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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	96%	0%	4%
Design Total		**98%**	**0%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	90%	7%	3%
	VIII: Appropriate Improvement Strategies	43%	57%	0%
Implementation Total		**75%**	**23%**	**2%**
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.49—Quality Improvement Project Outcomes
Health Plan of San Joaquin—San Joaquin County
July 1, 2013, through June 30, 2014

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%	80.7%	‡

¥ 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.50—Quality Improvement Project Domain(s) of Care and Interventions
Health Plan of San Mateo—San Mateo County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Sent notifications by mail to non-SPD members within two weeks of discharge that highlighted the need for them to contact their primary care physician (PCP) for follow-up and include contact information for the MCP's care coordination department. ◆ Implemented a process to send quarterly reports to PCPs with the highest readmission rates.
QIP #2—Increasing Timeliness of Prenatal Care		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A, T	◆ Conducted outbound calls to eligible members. ◆ Maintained and catalogued records and forms from the pay-for-performance (P4P) program for use as leads during the HEDIS process. ◆ Redesigned reminder forms to be more meaningful to members. ◆ Reached out to providers who could benefit from the P4P program, and investigated why the providers are not participating. ◆ Researched ways to conduct outreach to members younger than 21 years of age to identify effective strategies to engage these members in the MCP's incentive programs. ◆ Reestablished community partnerships.

Table C.51—Quality Improvement Project Validation Activity
Health Plan of San Mateo—San Mateo County
July 1, 2013, through June 30, 2014

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	Annual Submission	69%	86%	*Partially Met*
	Annual Resubmission 1	94%	100%	*Met*
Internal QIPs				
Increasing Timeliness of Prenatal Care	Annual Submission	74%	90%	*Partially Met*
	Annual Resubmission 1	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.52—Quality Improvement Project Average Rates*
Health Plan of San Mateo—San Mateo County
(Number = 4 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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%	5%	5%
Design Total		**96%**	**2%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	77%	12%	12%
	VIII: Appropriate Improvement Strategies	50%	33%	17%
Implementation Total**		**68%**	**18%**	**13%**
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.

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

Table C.53—Quality Improvement Project Outcomes
Health Plan of San Mateo—San Mateo County
July 1, 2013, through June 30, 2014

QIP #1—Increasing Timeliness of Prenatal Care				
Study Indicator: Percentage of members who 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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
85.3%	83.2%	81.9%	84.2%	‡

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

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

Table C.54—Quality Improvement Project Domain(s) of Care and Interventions
Inland Empire Health Plan—Riverside/San Bernardino Counties
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Developed a process to provide timely notification to primary care providers of their members' admissions and discharges, including notification of medications at discharge. ◆ Enhanced the transitions of care program for all lines of business by staffing appropriately, developed an identification process to identify members at high risk for readmissions, developed targeted interventions for members transitioning from one setting to another, and addressed members' behavioral health issues. ◆ Created the *Knowmymeds* portal for the MCP and providers to conduct medication reconciliation.
QIP #2—Attention Deficit Hyperactivity Disorder (ADHD) Management		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Made member health data available to providers via an electronic health record on the IEHP provider website. ◆ Posted newly improved provider ADHD member rosters on the IEHP provider website monthly. ◆ The Behavioral Health Advisory Committee discussed education, coordination of care, and best practices in the area of ADHD.
QIP #3—Comprehensive Diabetes Care		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.

Table C.55—Quality Improvement Project Validation Activity
Inland Empire Health Plan—Riverside/San Bernardino Counties
July 1, 2013, through June 30, 2014

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	Annual Submission	69%	71%	*Partially Met*
	Annual Resubmission 1	100%	100%	*Met*
Internal QIPs				
Attention Deficit Hyperactivity Disorder (ADHD) Management	Annual Submission	64%	57%	*Partially Met*
Comprehensive Diabetes Care	Study Design Submission	44%	14%	*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.56—Quality Improvement Project Average Rates*
Inland Empire Health Plan—Riverside/San Bernardino Counties
(Number = 5 QIP Submissions, 3 QIP Topics)
July 1, 2013, through June 30, 2014

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)	70%	30%	0%
	IV: Correctly Identified Study Population	60%	40%	0%
	V: Valid Sampling Techniques (if sampling is used)	83%	17%	0%
	VI: Accurate/Complete Data Collection	77%	14%	9%
Design Total		**78%**	**19%**	**3%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	69%	19%	13%
	VIII: Appropriate Improvement Strategies	43%	57%	0%
Implementation Total		**61%**	**30%**	**9%**
Outcomes	IX: Real Improvement Achieved**	33%	33%	33%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**50%**	**25%**	**25%**

*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.57—Quality Improvement Project Outcomes
Inland Empire Health Plan—San Bernardino/Riverside County
July 1, 2013, through June 30, 2014

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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
17.7%	19.3%	22.3%*	21.0%	Yes
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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
17.0%	15.2%	21.4%**	17.4%	‡

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

***** Statistically significant improvement over baseline (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.58—Quality Improvement Project Domain(s) of Care and Interventions
Kaiser North—Sacramento County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ A transition care pharmacist focused on high-risk members (defined as those with transition concerns) and conducted medication reconciliations and bedside member education, which was tailored to fit the needs of the member/family, to ensure understanding of current and new medications. ◆ A registered nurse or hospital-based physician called high-risk members within 48 hours of discharge to follow up on key items in the plan of care essential to keeping the member safely at home. The conversation was tailored to address the member's specific discharge instructions/plan. ◆ Prior to discharge, the MCP scheduled members for a follow-up appointment within a maximum of seven days. The appointment information was included in the printed discharge instructions and a reminder was given to the member based on member preference (i.e., via automated telephone call, email, or text).
QIP #2—Childhood Immunization Status (CIS)		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A, T	◆ Conducted outreach programs via telephone and/or email to parents/guardians when a child was overdue for immunizations. ◆ Changed the MCP's workflow to facilitate on-demand requests for immunizations while a child is in the medical office exam room. ◆ Trained pediatric providers on how to communicate to a parent/family who is refusing vaccines for their child and documented the interaction in the medical record.

Table C.59—Quality Improvement Project Validation Activity
Kaiser North—Sacramento County
July 1, 2013, through June 30, 2014

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	Annual Submission	88%	100%	*Met*
Internal QIPs				
Childhood Immunization Status	Annual Submission	69%	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.60—Quality Improvement Project Average Rates*
Kaiser North—Sacramento County
(Number = 3 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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	92%	8%	0%
Design Total		**97%**	**3%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	67%	17%	17%
	VIII: Appropriate Improvement Strategies	67%	33%	0%
Implementation Total		**67%**	**22%**	**11%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**

*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.61—Quality Improvement Project Domain(s) of Care and Interventions
Kaiser South—San Diego County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ The MCP established the Bridge Clinic pilot which allowed a physician and social worker to visit members within seven days of discharge for one hour. ◆ The home health provider conducted home health visits within 24 hours of discharge. ◆ Based on risk level, the MCP made a post-discharge call to all high-risk members to ensure appointments were made, address medication issues, confirm durable medical equipment was delivered, and confirm that home health had contacted or seen the member. ◆ Pharmacists provided education and medication reconciliation at the member's bedside prior to discharge. The pharmacists also sold necessary medications and offered medical financial assistance to members who could not afford the medications.
QIP #2—Children and Adolescents' Access to Primary Care Practitioners		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Improved physician culture and access by performing monthly tracking on W-34 rates. ◆ Modified physician schedules to allow for more flexibility of well visits. ◆ Provided employee outreach programs through letters and telephone calls and identified members monthly who have not had well visits.

Table C.62—Quality Improvement Project Validation Activity
Kaiser South—San Diego County
July 1, 2013, through June 30, 2014

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	Annual Submission	81%	86%	*Partially Met*
	Annual Resubmission 1	94%	100%	*Met*
Internal QIPs				
Children's Access to Primary Care Practitioners	Annual Submission	65%	86%	*Partially Met*
	Annual Resubmission 1	73%	86%	*Partially Met*
	Annual Resubmission 2	81%	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 South—San Diego County
(Number = 5 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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	85%	15%	0%
Design Total		**94%**	**6%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	81%	3%	16%
	VIII: Appropriate Improvement Strategies	56%	44%	0%
Implementation Total		**73%**	**17%**	**10%**
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.64—Quality Improvement Project Outcomes
Kaiser South—San Diego County
July 1, 2013, through June 30, 2014

QIP #1—Children's Access to Primary Care Practitioners			
Study Indicator 1: Number of children who have had one or more visits with a PCP during the measurement year			
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¥**
94.4%	94.4%	‡	‡
Study Indicator 2: Number of children who have had a well visit during the measurement year			
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¥**
68.6%	70.7%	‡	‡

¥ 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.65—Quality Improvement Project Domain(s) of Care and Interventions
Kern Family Health Care—Kern County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Implemented a comprehensive transitions of care pilot program which includes the following activities: ▪ Medication therapy management • Medication reconciliation • Potential interactions and patient education ▪ Discharge advocate • Standardized comprehensive discharge planning (assist with arranging appointments, transportation, and durable medical equipment) ▪ Post-discharge clinic and home visit program • Two-to-three-day follow-up clinical reevaluation and additional care coordination ▪ Health coach • Member self-management • Symptom recognition • Post-discharge care plan • Follow-up compliance
QIP #2—Comprehensive Diabetic Quality Improvement Plan		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Established the Delano Regional Medical Center Diabetic Clinic, open to all eligible members with diabetes and who are 18 years of age or older. ◆ Continued the Text Message Pilot Program in order to increase HbA1c testing. ◆ Continued the Pay-for-Performance program for providers. ◆ Continued to receive monthly laboratory data files from various laboratories to use as supplemental data.

Table C.66—Quality Improvement Project Validation Activity
Kern Family Health Care—Kern County
July 1, 2013, through June 30, 2014

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	Annual Submission	81%	86%	*Partially Met*
	Annual Resubmission 1	94%	100%	*Met*
Internal QIPs				
Comprehensive Diabetic Quality Improvement Plan	Annual Submission	71%	80%	*Partially Met*
	Annual Resubmission 1	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.67—Quality Improvement Project Average Rates*
Kern Family Health Care—Kern County
(Number = 4 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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)**	88%	13%	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		**98%**	**2%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	81%	8%	12%
	VIII: Appropriate Improvement Strategies	40%	60%	0%
Implementation Total**		**69%**	**22%**	**8%**
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.

Table C.68—Quality Improvement Project Outcomes
Kern Family Health Care—Kern County
July 1, 2013, through June 30, 2014

QIP #1—Comprehensive Diabetic Quality Improvement Plan			
Study Indicator 1: The percentage of diabetic members 18–75 years of age who had HbA1c testing during the measurement year.			
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¥**
82.1%	80.3%	‡	‡
Study Indicator 2: The percentage of diabetic members 18–75 years of age who had LDL-C screening during the measurement year.			
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¥**
79.4%	76.3%	‡	‡
Study Indicator 3: The percentage of diabetic members 18–75 years of age who had diabetic retinal eye exam screening during the measurement year or a negative diabetic retinal eye exam result the year prior to the measurement year.			
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¥**
52.6%	45.8%*	‡	‡

¥ 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 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.69—Quality Improvement Project Domain(s) of Care and Interventions
L.A. Care Health Plan—Los Angeles County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Implemented a transition of care program that provided targeted case management and care coordination for members while they were in the hospital through 30 days post-discharge from the facility. The intervention took a member-centered approach to identifying barriers and coordinating post-discharge care, and brought together an interdisciplinary team. For at-risk patients, this team includes transition of care nurses, care coordinators, social workers, primary care providers, disease management nurses and coordinators, behavioral health specialists, pharmacists, and long-term supports and services specialists. The members were stratified into three categories—high-risk, moderate-risk, and low-risk—and received different levels of interventions, including: ▪ Coordination of care services. ▪ Assistance with follow-up appointments. ▪ Assistance with transportation. ▪ Medication reconciliation and compliance. ▪ Identification of special needs and support network. ▪ Establishment of member-specific goals and objectives.
QIP #2—Improving HbA1c and Diabetic Retinal Exam Screening Rates		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Continued live-agent calls with appointment scheduling assistance program. ◆ Continued the provider Pay-for-Performance incentive program. ◆ Initiated a member incentive program.

Table C.70—Quality Improvement Project Validation Activity
L.A. Care Health Plan—Los Angeles County
July 1, 2013, through June 30, 2014

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	Annual Submission	81%	86%	*Partially Met*
	Annual Resubmission 1	100%	100%	*Met*
Internal QIPs				
Improving HbA1c and Diabetic Retinal Exam Screening Rates	Annual Submission	74%	90%	*Partially Met*
	Annual Resubmission 1	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.71—Quality Improvement Project Average Rates*
L.A. Care Health Plan—Los Angeles County
(Number = 4 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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	95%	5%	0%
Design Total		**98%**	**2%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	88%	8%	4%
	VIII: Appropriate Improvement Strategies	58%	42%	0%
Implementation Total		**79%**	**18%**	**3%**
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.72—Quality Improvement Project Outcomes
L.A. Care Health Plan—Los Angeles County
July 1, 2013, through June 30, 2014

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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
82.1%	85.0%	83.8%	84.3%	‡
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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
52.8%	50.7%	50.7%	49.8%	‡

¥ 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.73—Quality Improvement Project Domain(s) of Care and Interventions
Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino, Sacramento, and San Diego Counties
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Conducted inpatient review rounds with the MCP's medical director and utilization management staff to discuss members currently hospitalized. (Members are identified for case management prior to hospital discharge.) ◆ Case managers made a "Welcome Home Call" to the member within 24 hours of discharge. The purpose of the call was to both determine that the member understood the discharge instructions and confirm that the member scheduled the follow-up appointment with the primary care physician (PCP). ◆ Conducted Interdisciplinary Care Team meetings with the MCP's medical directors and care/case managers to address all aspects of members' health care, including medical, behavioral, and social health needs. Care transition clinicians communicated discharge plans to physicians and other community service providers to ensure appropriate follow-up care of members after discharge. ◆ Encouraged members to be active participants in their own care. ◆ Planned to hire five more care/case managers plus community health workers and support staff as needed. ◆ Reorganized discharged member assignment to care/case managers to promote timely care coordination and discharge follow-up. ◆ Upon admission to the MCP case management program, provided timely verbal and written communication of member issues, interventions, and medication adjustments to the PCP. ◆ Notified PCPs of member admission and discharge and provided discharge plans to the PCPs. ◆ Facilitated safe discharges by making on-call discharge staff available after hours, on weekends, and on holidays. ◆ Care managers arranged for in-home support services so members received required care in the community. Additionally, community health workers were assigned to members to provide social support. ◆ Care managers, community connectors, or member services staff assisted members in receiving all transportation related to health care. ◆ Care managers, community connectors, and member services staff continually educated members regarding their plan benefits, health problems, treatment requirements and options, use of translator services, and use of other support services to optimize recovery and prevent health problems.

QIP #2—Improving Hypertension Control		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Provider Engagement Project: The MCP provided an expert resource who worked with designated provider groups to improve provision and documentation of quality health care for members. ◆ Provider Profile Scorecard: The MCP set goals and informed providers of the goals relevant to quality performance. ◆ Quality Improvement Redesign: The MCP implemented quality improvement redesign to align all organization-wide performance activities with strategic goals, standardize best practice tools and trainings, and establish sufficient and efficient resources.

Table C.74—Quality Improvement Project Validation Activity
Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino, Sacramento, and San Diego Counties
July 1, 2013, through June 30, 2014

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	All counties received the same score	Annual Submission	69%	86%	*Partially Met*
		Annual Resubmission 1	100%	100%	*Met*
Internal QIPs					
Improving Hypertension Control	Riverside/San Bernardino	Annual Submission	77%	90%	*Not Met*
		Annual Resubmission 1	94%	100%	*Met*
	Sacramento	Annual Submission	74%	90%	*Not Met*
		Annual Resubmission 1	91%	100%	*Met*
	San Diego	Annual Submission	79%	90%	*Not Met*
		Annual Resubmission 1	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.75—Quality Improvement Project Average Rates*
Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino, Sacramento, and San Diego Counties
(Number = 12 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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	95%	0%	5%
Design Total		**98%**	**0%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	86%	6%	8%
	VIII: Appropriate Improvement Strategies**	51%	17%	31%
Implementation Total		**75%**	**10%**	**15%**
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.

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

Table C.76—Quality Improvement Project Outcomes
Molina Healthcare of California Partner Plan, Inc.—Riverside/San Bernardino, Sacramento, and San Diego Counties
July 1, 2013, through June 30, 2014

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**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
Riverside/San Bernardino	59.6%	42.6%*	53.7%*	53.8%	‡
Sacramento	56.6%	50.8%	53.1%	51.3%	‡
San Diego	66.4%	58.3%*	55.0%	52.8%	‡

¥ 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.77—Quality Improvement Project Domain(s) of Care and Interventions
Partnership HealthPlan of California—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Marin, Mendocino, Napa/Solano/ Yolo, and Sonoma	Q, A	◆ Provided quarterly reports to all PCPs showing their readmissions rates and, when requested, a drill-down at the patient level. ◆ Increased the number of hospitals reporting readmissions rates electronically, thereby reducing delays in the MCP being notified of hospitalizations. ◆ Tested with three primary care sites an email notification system designed to provide timely alerts of a patient hospitalization. ◆ Implemented a pay-for-performance program. ◆ Hired a care transition nurse to work in the Sonoma region to reach more members who need these services. ◆ Increased the case load for the care transition nurse by testing and improving the referral system for identifying members at risk for readmissions. ◆ Enrolled into care transitions and case management the top five patients with the most readmissions within a 12-month period.
QIP #2—Childhood Immunization Status—Combo 3			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Mendocino	Q, A, T	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.
QIP #3—Improving Access to Primary Care for Children and Adolescents			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Napa/Solano/ Yolo and Sonoma	A	◆ Continued patient reminder calls. ◆ Gathered data at the individual provider level, and identified which providers and members may benefit most from interventions. ◆ Interviewed providers and members to identify specific areas of improvement, and proposed solutions to implement interventions.

QIP #4—Improving the Timeliness of Prenatal and Postpartum Care			
Clinical/ Nonclinical	**Counties**	**Domains of Care**	**Interventions**
Clinical	Marin	Q, A, T	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.

Table C.78—Quality Improvement Project Validation Activity
Partnership HealthPlan of California—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties
July 1, 2013, through June 30, 2014

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	All counties received the same score.	Annual Submission	81%	86%	*Partially Met*
		Annual Resubmission 1	100%	100%	*Met*
Internal QIPs					
Childhood Immunization Status—Combo 3	Mendocino	Study Design Submission	83%	83%	*Not Met*
		Study Design Resubmission 1	100%	100%	*Met*
Improving Access to Primary Care for Children and Adolescents	Napa/Solano/Yolo	Annual Submission	92%	100%	*Met*
	Sonoma	Annual Submission	84%	100%	*Met*
Improving the Timeliness of Prenatal and Postpartum Care	Marin	Study Design Submission	75%	83%	*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.79—Quality Improvement Project Average Rates*
Partnership HealthPlan of California—Marin, Mendocino, Napa/Solano/Yolo, and Sonoma Counties
(Number = 14 QIP Submissions, 4 QIP Topics)
July 1, 2013, through June 30, 2014

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**	83%	13%	5%
Design Total		**93%**	**5%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	88%	4%	8%
	VIII: Appropriate Improvement Strategies	82%	18%	0%
Implementation Total**		**86%**	**9%**	**6%**
Outcomes	IX: Real Improvement Achieved	75%	25%	0%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**75%**	**25%**	**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.80—Quality Improvement Project Outcomes
Partnership HealthPlan of California—Napa/Solano/Yolo and Sonoma Counties
July 1, 2013, through June 30, 2014

QIP #1—Improving Access to Primary Care for Children and Adolescents				
Study Indicator 1: Percentage of 12-to-24-month-old members with one or more visits with a PCP during the measurement year				
County	**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¥**
Napa/Solano/Yolo	94.9%	96.5%*	‡	‡
Sonoma	95.2%	96.3%	‡	‡
Study Indicator 2: Percentage of 25-month-to-6-year-old members with one or more visits with a PCP during the measurement year				
County	**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¥**
Napa/Solano/Yolo	82.9%	86.4%*	‡	‡
Sonoma	86.5%	88.6%*	‡	‡
Study Indicator 3: Percentage of 7-to-11- year-old members with one or more visits with a PCP during the measurement year or the year prior to the measurement year				
County	**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¥**
Napa/Solano/Yolo	80.4%	86.4%*	‡	‡
Sonoma	83.3%	85.7%*	‡	‡
Study Indicator 4: Percentage of 12-to-19-year-old members with one or more visits with a PCP during the measurement year or the year prior to the measurement year				
County	**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¥**
Napa/Solano/Yolo	77.3%	84.9%*	‡	‡
Sonoma	84.4%	88.2%*	‡	‡

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

* Statistically significant improvement over baseline (p value < 0.05).

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

Table C.81—Quality Improvement Project Domain(s) of Care and Interventions
San Francisco Health Plan—San Francisco County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Implemented a comprehensive pay-for-performance program that assigns points (and dollars) to medical groups and clinics to ensure that they were actively working with the MCP's members to decrease readmissions. The MCP contracted with the Center for Excellence in Primary Care to provide intensive training for clinic care managers. The measures are: ▪ Each clinic or medical group will develop a personalized intervention that ensures that patients are contacted within seven days of discharge. ▪ The contact may be in the form of an in-person visit or telephone call by the primary care provider or a care team member. ▪ The contact may include the following: • Education about red flag symptoms. • Medication reconciliation. • Medication self-management. • Referral services. • Scheduling/reminder of post-discharge appointment. ▪ Clinics and medical groups must report findings quarterly as a follow-up to the intervention.
QIP #2—Improving the Patient Experience		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Access Program ▪ Implemented the Rapid Dramatic Performance Improvement Program, which addressed infrastructure changes that clinics needed to make in order to improve appointment availability and flow for increased patient access. ▪ Launched a telephone access improvement initiative which will standardize and improve processes across differing clinic systems in order to establish a call center. ◆ Provider Communication Program ▪ Held a three-day training session for providers on improving communication and patient-centeredness while effectively using an electronic health record during patient visits. ▪ Implemented the Customer Service Action Series intervention to provide training on tactical protocols for responding to challenging patients, handling patient concerns proactively, and providing patient-centered personalized service.

Table C.82—Quality Improvement Project Validation Activity
San Francisco Health Plan—San Francisco County
July 1, 2013, through June 30, 2014

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	Annual Submission	94%	86%	*Partially Met*
	Annual Resubmission 1	100%	100%	*Met*
Internal QIPs				
Improving the Patient Experience	Annual Submission	86%	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.83—Quality Improvement Project Average Rates*
San Francisco Health Plan—San Francisco County
(Number = 4 QIP Submissions, 2 QIP Topics)
July 1, 2013, through June 30, 2014

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%	6%	0%
	VIII: Appropriate Improvement Strategies**	63%	38%	0%
Implementation Total		**85%**	**15%**	**0%**
Outcomes	IX: Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**

*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.84—Quality Improvement Project Domain(s) of Care and Interventions
Santa Clara Family Health Plan—Santa Clara County
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Added additional case management staff to increase the number of SPD members engaged in case management services. ◆ Implemented a post-discharge call policy and procedure. ◆ Implemented a discharge plan documentation pilot program with Stanford Hospital wherein, upon a member being discharged, the MCP's concurrent review team becomes responsible for downloading the electronic discharge plans from Stanford's online system. The discharge plan information was used in the care planning and care coordination processes.
QIP #2—Childhood Obesity Partnership and Education		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Implemented 5 Keys to Raising Healthy, Happy Eaters Program in which parents were educated on the consequences of abnormal BMI and addressed any perceptions by parents that their children do not have a weight problem. ◆ Implemented Pediatric Healthy Lifestyle Centers which focused on family-centered, community-linked preventive care, lifestyle management, and medical interventions for children and adolescents. ◆ Implemented the Pediatric Weight Management Program which promoted lifelong healthy eating and exercise habits for overweight children, adolescents, and their families. ◆ Implemented member outreach programs which included telephone calls to eligible members to inform and encourage them to participate in programs. ◆ Partnered with Weight Watchers to offer programs to eligible members at no cost to the members. ◆ Offered nutrition classes that focused on healthy eating, physical activity, meal planning, and food safety.
QIP #3—Diabetic Retinopathy Improvement and Prevention by Screening		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.

Table C.85—Quality Improvement Project Validation Activity
Santa Clara Family Health Plan—Santa Clara County
July 1, 2013, through June 30, 2014

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	Annual Submission	88%	86%	*Partially Met*
	Annual Resubmission 1	100%	100%	*Met*
Internal QIPs				
Childhood Obesity Partnership and Education	Annual Submission	44%	43%	*Not Met*
	Annual Resubmission 1	30%	29%	*Not Met*
Diabetic Retinopathy Improvement and Prevention by Screening	Study Design Submission	83%	71%	*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.86—Quality Improvement Project Average Rates*
Santa Clara Family Health Plan—Santa Clara County
(Number = 6 QIP Submissions, 3 QIP Topics)
July 1, 2013, through June 30, 2014

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)	83%	17%	0%
	III: Clearly Defined Study Indicator(s)**	71%	14%	14%
	IV: Correctly Identified Study Population	67%	0%	33%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection**	79%	4%	18%
Design Total		**83%**	**5%**	**12%**
Implementation	VII: Sufficient Data Analysis and Interpretation**	63%	21%	17%
	VIII: Appropriate Improvement Strategies	25%	42%	33%
Implementation Total		**50%**	**28%**	**22%**
Outcomes	IX: Real Improvement Achieved	0%	0%	100%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**0%**	**0%**	**100%**

*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.87—Quality Improvement Project Outcomes
Santa Clara Family Health Plan—Santa Clara County
July 1, 2013, through June 30, 2014

QIP #1—Childhood Obesity Partnership and Education			
Study Indicator: The percentage of identified children aged 2 to 18 years with BMI ≥95th percentile for age and gender who attended at least one eligible program during the measurement year.			
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¥**
18.6%	2.9%*	‡	‡

¥ 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 baseline and Remeasurement 1 results could not be compared due to changes in the methodology.

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

Table C.88—Quality Improvement Project Domain(s) of Care and Interventions
Senior Care Action Network Health Plan—Los Angeles/Riverside/San Bernardino Counties
July 1, 2013, through June 30, 2014

QIP #1—All-Cause Readmissions		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Implemented a care transitions program that included a multimedia sharing and messaging component wherein care transition coaches developed and recorded individualized video messages sent electronically to the member and/or the member's caregivers. ◆ Implemented a home-visit pilot to remove barriers related to readmissions. The home visit helped improve members' understanding of their discharge plans and ensured that they received needed support services. ◆ Partnered with skilled nursing facilities and acute care facilities to improve care transition to skilled nursing facilities and reduce readmissions to the acute care environment.
QIP #2—Care for Older Adults		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ Improved provider and member education. ◆ Realigned network management to improve outreach and communication with providers. ◆ Collaborated with medical directors and provider networks to improve communication in geriatric education and barrier identification. ◆ Implemented provider incentive programs. ◆ Sent information to members and conducted member focus groups. ◆ Developed standardized screening tools and clinical practice guidelines.
QIP #3—Patient Safety Analysis—Use of High-Risk Medication in the Elderly		
Clinical/ Nonclinical	**Domains of Care**	**Interventions**
Clinical	Q, A	◆ This QIP was in the Design stage; therefore, the MCP submitted no intervention information.

Table C.89—Quality Improvement Project Validation Activity
Senior Care Action Network Health Plan—Los Angeles/Riverside/San Bernardino Counties
July 1, 2013, through June 30, 2014

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	Annual Submission	75%	86%	*Partially Met*
	Annual Resubmission 1	100%	100%	*Met*
Internal QIPs				
Care for Older Adults	Annual Submission	97%	100%	*Met*
Patient Safety Analysis—Use of High-Risk Medication in the Elderly	Study Design Submission	80%	80%	*Partially 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.90—Quality Improvement Project Average Rates*
Senior Care Action Network Health Plan—Los Angeles/Riverside/San Bernardino Counties
(Number = 5 QIP Submissions, 3 QIP Topics)
July 1, 2013, through June 30, 2014

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)	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	91%	9%	0%
Design Total		**95%**	**5%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	82%	0%	18%
	VIII: Appropriate Improvement Strategies	86%	14%	0%
Implementation Total		**83%**	**4%**	**13%**
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.91—Quality Improvement Project Outcomes
Senior Care Action Network Health Plan—Los Angeles/Riverside/San Bernardino Counties
July 1, 2013, through June 30, 2014

QIP #1—Care for Older Adults			
Study Indicator 1: 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%*	75.5%	Yes
Study Indicator 2: 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%*	65.2%	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.

* Statistically significant improvement over baseline (p value < 0.05).

Appendix D. Grid of 2012–13 EQR Recommendations and Medi-Cal Managed Care Division's Follow-Up During 2013–14 Reporting Period

The table below provides the 2012–13 external quality review recommendations and the actions taken (through June 30, 2014) by the Department of Health Care Service's (DHCS's) Medi-Cal Managed Care Division's (MMCD's)[1] that address the recommendations.

2012–13 External Quality Review Recommendation	MMCD Actions Taken through June 30, 2014, that Address the Recommendation
1. Engage in the following efforts related to compliance reviews:	
a. Continue implementation of DHCS's new monitoring protocols to ensure the managed care health plans' (MCPs') progress with addressing findings and deficiencies is actively and continuously monitored until full resolution is achieved.	MMCD has implemented a new monitoring and oversight process which requires MCPs to submit a corrective action plan to DHCS for all medical audits/surveys. MCPs must demonstrate that all findings are ameliorated.
b. Ensure a comprehensive audit is conducted at least once within a three-year period with all MCPs.	Beginning in 2015, medical audits are conducted annually by DHCS.
c. Compare the compliance tool used for the various DHCS reviews to the Code of Federal Regulations to ensure all federal requirements are assessed within the three-year required time frame.	DHCS has systems in place to ensure its managed care contracts and respective All Plan and Policy letters are in compliance with the Code of Federal Regulations. DHCS's MMCD and Audits & Investigation Division have a firm commitment to conduct annual health plan audits and ensure all federal requirements are assessed on an annual basis.
2. Engage in the following efforts related to performance measures:	
a. 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.	DHCS implemented a corrective action plan in November 2013 with one MCP that had demonstrated poor performance over consecutive years. DHCS also provided the MCP with intensive monthly monitoring and technical assistance along with requirements for quarterly reports of plan progress in all aspects of its rapid-cycle improvement activities. The corrective action plan also consists of quarterly meetings with DHCS leadership to discuss progress on performance improvement.

[1] MMCD was reorganized into two divisions as of December 2014—Managed Care Operations Division and Managed Care Quality and Monitoring Division.

2012–13 External Quality Review Recommendation	MMCD Actions Taken through June 30, 2014, that Address the Recommendation
b. Identify State-level barriers and develop strategies for addressing the barriers.	The 2014 MMCD Quality Strategy Report (submitted October 2014) identifies areas for key State focus (maternal child health, postpartum care, immunizations, and chronic disease [diabetes care, control of hypertension, and tobacco cessation]). Through direct feedback from the MCPs (via conference calls, workgroups, plan meetings, and discussions on plan IPs and QIPs), common barriers were identified. The Quality Strategy Report outlines the strategies that are in place or will be implemented in the coming year to address the key focus areas.
3. Engage in the following efforts related to improvement plans (IPs):	
a. 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.	DHCS revised the IP submission and evaluation forms in 2013–14. DHCS now requires MCPs to conduct a thorough barrier analysis and submit documentation of appropriately identified barriers that are supported by MCP data.
b. Continue to assess if development of an IP is needed when an MCP has a quality improvement project (QIP) related to a performance measure with a rate below the minimum performance level (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.	The IP and QIP processes are now integrated and better support focused and more efficient MCP QI activities and rapid-cycle improvement. DHCS efforts are focused on quarterly IP monitoring of plan efforts with Plan-Do-Study-Act reporting and technical assistance calls.
c. 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.	See 3.a. and 3.b. for documentation of the actions taken by DHCS to address this recommendation.
4. Engage in the following efforts related to QIPs:	
a. Continue to assess the appropriateness of MCPs' proposed QIP topics to ensure their relevance to the Medi-Cal Managed Care program (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.	MCPs must seek pre-approval of QIP topics from DHCS, and MCPs are strongly recommended to align their QIP topics with demonstrated areas of poor performance and/or EQRO recommendations. MCPs must submit a QIP Topic Proposal Form and respond to a number of questions that are intended to guide the MCP in selecting a topic identified as an area that needs improvement. DHCS may approve the topic, request additional information, or suggest a technical assistance call with the EQRO to help the MCP identify topics that are relevant, more closely aligned with areas of poor performance, and most likely to benefit members.

2012–13 External Quality Review Recommendation	MMCD Actions Taken through June 30, 2014, that Address the Recommendation
b. Continue to provide technical assistance to the MCPs, in collaboration with the external quality review organization, to support the MCPs in designing valid QIPs and increasing the likelihood of statistically significant and sustained improvement.	DHCS is engaging in new and innovative efforts with HSAG to provide technical assistance to MCPs. These efforts follow national trends to improve quality.
c. 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.	DHCS efforts are focused on quarterly monitoring of both IP and QIP plan efforts with PDSA reporting and technical assistance calls completed on a quarterly basis for plans with substandard performance issues.
5. Engage in the following effort regarding Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2]:	
a. Consider implementing minimum performance requirements for CAHPS, similar to DHCS's assignment of performance measures, as a mechanism for addressing low MCP performance.	DHCS is utilizing CAHPS performance data to drive improvement, such as conducting data analysis related to Smoking and Tobacco Use Cessation and sharing the results with MCPs. DHCS will establish minimum requirements related to these efforts.
6. Engage in the following efforts regarding general encounter data validation information:	
a. DHCS should clarify with the MCPs on how to identify and submit long-term care (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.	MCPs are transitioning to a new encounter data processing system that utilizes industry-standard transaction types. This transition will be completed during the first half of 2015. This system will identify LTC records uniformly for all MCPs.
b. 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 has reviewed the encounter data submitted by all MCPs as part of its process for transitioning them to its new encounter data processing system. Throughout the process, DHCS identified and addressed specific data quality issues with each MCP.

[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

2012–13 External Quality Review Recommendation	MMCD Actions Taken through June 30, 2014, that Address the Recommendation
c. DHCS should verify whether there are any Child Health and Disability Prevention encounters classified under the incorrect claim type for Santa Clara Family Health Plan.	DHCS has reviewed the encounter data submitted by all MCPs as part of its process for transitioning them to its new encounter data processing system. Throughout the process, DHCS identified and addressed specific data quality issues with each MCP.
d. 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 has requested and received edits documentation from its fiscal intermediary, but is transitioning away from using this system for encounter data processing.
e. DHCS should request documentation from the 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 has requested and received edits documentation from its ITSD but is transitioning away from using this system for encounter data processing. This transition will be completed during the first half of 2015.
f. 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.	DHCS is transitioning to a new encounter data processing system that will allow for the identification of last positive claims. This transition will be completed during the first half of 2015.
g. 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.	MCPs are contractually required to notify DHCS when system changes occur.
h. To improve the quality and data processing efficiency, DHCS should consider reducing the number of formats used for data submission.	DHCS is transitioning to a new encounter data processing system that utilizes industry standard transaction types. This transition will be completed during the first half of 2015.

2012–13 External Quality Review Recommendation	MMCD Actions Taken through June 30, 2014, that Address the Recommendation
7. Engage in the following efforts regarding encounter data validation record completeness:	
a. 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.	DHCS is developing a variety of quality measures that will be applied to encounter data submitted to DHCS. These measures assess data quality in the domains of completeness, accuracy, reasonability, and timeliness.
8. Engage in the following efforts regarding encounter data validation element completeness and accuracy:	
a. 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 is transitioning to a new encounter data processing system that will allow for the adjustment of system edits as needed to meet business and data-quality requirements. This transition will be completed during the first half of 2015.
b. 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.	DHCS is transitioning to a new encounter data processing system that will only accept 10-digit National Provider Identifiers on submitted encounters. This transition will be completed during the first half of 2015.
c. 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 is developing a variety of quality measures that will be applied to encounter data submitted to DHCS. These measures assess data quality in the domains of completeness, accuracy, reasonability, and timeliness. Data reasonability measures will focus on the population of specific data elements in submitted encounters. DHCS will use these measures to target areas where improvement is needed.

2012–13 External Quality Review Recommendation	MMCD Actions Taken through June 30, 2014, that Address the Recommendation
d. 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 is developing a variety of quality measures that will be applied to encounter data submitted to DHCS. These measures assess data quality in the domains of completeness, accuracy, reasonability, and timeliness. Data reasonability measures will focus on the population of specific data elements in submitted encounters. DHCS will use these measures to target areas where improvement is needed. DHCS is also transitioning to a new encounter data processing system that will only accept valid National Provider Identifiers on submitted encounters. This transition will be completed during the first half of 2015.
e. 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 is transitioning to a new encounter data processing system that will utilize industry-standard transaction types that can capture the full diagnosis profile for services rendered. This new system will also deny individual encounter records that contain invalid codes. This transition will be completed during the first half of 2015.
f. 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 is developing a variety of quality measures that will be applied to encounter data submitted to DHCS. These measures assess data quality in the domains of completeness, accuracy, reasonability, and timeliness. Data reasonability measures will focus on the population of non-required data elements in specific encounters.
g. 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 is transitioning to a new encounter data processing system that will utilize industry-standard transaction types. This transition will be completed during the first half of 2015.
h. 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 is transitioning to a new encounter data processing system that will allow for the adjustment of system edits as needed to meet business and data-quality requirements. DHCS will also include the validation of submitted encounters against beneficiary medical records as part of annual MCP audits. This transition will be completed during the first half of 2015.

2012–13 External Quality Review Recommendation	MMCD Actions Taken through June 30, 2014, that Address the Recommendation
i. DHCS should investigate the reasons for the element omission on the Drug/Medical Supply data element.	DHCS has reviewed the encounter data submitted by all MCPs as part of its process for transitioning them to its new encounter data processing system. Throughout the process, DHCS identified and addressed specific data quality issues with each MCP.
j. DHCS should determine a standard way to determine the Days of Stay so that the information is consistent and comparable between the MCPs.	DHCS is transitioning to a new encounter data processing system that will utilize industry-standard transaction types. This will allow for greater consistency in reporting across MCPs. This transition will be completed during the first half of 2015.