

Chapter 2: Measurement Set Summaries

Healthcare Effectiveness Data and Information Set (HEDIS)

Purpose

The Healthcare Effectiveness Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA), is the most widely used health care quality measurement system in the U.S. HEDIS is designed to provide a standardized method for evaluating and comparing health plan performance across key areas of care.

In California, the Department of Health Care Services (DHCS) requires Medi-Cal Managed Care Plans (MCPs) to report a subset of HEDIS measures annually. These measures are used to monitor the quality of care delivered to Medi-Cal members and to identify opportunities for improvement.

Audience

HEDIS performance data are used by:

- Medi-Cal Managed Care Plans (MCPs)
- Department of Health Care Services (DHCS)
- National Committee for Quality Assurance (NCQA),
- Health care purchasers and policymakers
- Health care providers and health centers

Why HEDIS Matters to Health Centers

Although HEDIS is a health plan reporting system, it has significant influence on health center quality improvement priorities.

Many of the clinical services measured through HEDIS are delivered in primary care settings, making health centers essential partners in improving performance. Health plans routinely use HEDIS data to identify performance gaps, prioritize improvement efforts, and design provider incentive programs.

Partnership HealthPlan of California (PHP) is an NCQA accredited health plan. The importance of HEDIS becomes more prominent as HEDIS scores and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results make up 50% of the accreditation assessment.

Several measures included in HEDIS also appear in other quality measurement systems, including UDS and the Primary Care Provider Quality Improvement Program (QIP). As a result,

For many health centers these overlapping measures represent some of the highest-leverage opportunities for quality improvement.

- Effectiveness of Care
- Access/Availability of Care
- Patient Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Reported Using Electronic Clinical Data Systems

The HEDIS Annual Project includes a data collection process that is completed between February and May to assess quality in the prior year, also known as the measurement year, January 1 – December 31.

A map of Northern California counties, color-coded to show different regions. The counties shown are: DEL Norte (dark red), SISKIYOU (dark blue), MODOC (dark blue), TRINITY (dark blue), SHASTA (dark blue), LASSEN (dark blue), HUMBOLDT (dark red), TEHAMA (light blue), PLUMAS (teal), MENDOCINO (green), SLENN (teal), BUTTE (teal), SIERRA (teal), LAKESIDE (green), COLUSA (teal), YUBA (teal), NEVADA (teal), PLACER (teal), SUTTER (teal), YOLO (teal), NAPA (dark brown), SONOMA (dark brown), and MARIN (dark brown).

Administrative Measures: which are calculated using claims, encounter, pharmacy, laboratory, and other electronic data sources. Performance is assessed across the entire eligible population.

Because many HEDIS measures rely on claims and encounter data, accurate documentation and complete encounter submission are important. Health centers play an important role in ensuring that services delivered to patients are reflected in reported performance.

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used to establish the MPLs and HPLs for the current reporting year. Managed care plans are contractually required to perform at or above the established MPLs. Managed care plans that have rates below the MPLs are frequently assigned mandated improvement projects by DHCS. With repeated low performance, managed care plans risk issuance of a formal DHCS Corrective Action Plan (CAP) as well as financial penalties.

QI Leader Takeaways

As a quality leader, it is important to understand how HEDIS influences organizational priorities and aligns with other measurement systems.

When developing a quality strategy:

- Focus on HEDIS measures that are a priority for the Partnership reporting region.
- Identify where measures overlap with UDS and QIP.
- Recognize that strong documentation and encounter data support HEDIS performance.
- Consider HEDIS measures as a part of a broader quality improvement portfolio rather than a stand-alone reporting requirement.

Within this toolkit, HEDIS is most useful when viewed alongside UDS, QIP, and other population health management initiatives. Understanding where measures align across systems can help health centers focus improvement efforts where they will have the greatest impact on patients, organizational performance, and incentive opportunities.

Resources

- <http://www.partnershiphp.org/Providers/Quality/Pages/HEDISLandingPage.aspx>
- <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>
- <http://www.ncqa.org/hedis-quality-measurement>

Primary Care Provider Quality Improvement Program (QIP)

Purpose

The Primary Care Provider Quality Improvement Program (QIP) is Partnership HealthPlan of California's (Partnership) provider incentive program designed to support improvements in quality, access, patient experience, and population health outcomes. The QIP is designed in collaboration with PHC providers.

The QIP combines financial incentives, performance measurement, and technical assistance to encourage primary care providers to focus on areas that have the greatest impact on patient outcomes and health system performance.

Unlike many quality improvement systems that are primarily designed for compliance or accountability, QIP is specifically designed to drive improvement.

Audience

The QIP performance data are used by:

- Partnership HealthPlan of California
- Health center leadership
- Quality improvement teams
- Clinical and operational leaders

Why QIP Matters to Health Centers

For many health centers, QIP represents the most direct connection between quality improvement efforts and financial incentives.

The program rewards organizations for improving performance on measures that are strongly associated with preventive care, chronic disease management, access, and patient experience. Many of these measures also align with UDS and HEDIS reporting requirements.

As a result, QIP can serve as an important strategic tool for focusing improvement efforts.

When health centers improve performance on high-alignment measures – or those that are also aligned with UDS and HEDIS – they may simultaneously improve performance across multiple reporting systems while also increasing eligibility for incentive payments.

For quality leaders, this alignment creates an opportunity to maximize the impact of limited quality improvement resources.

How Performance is Measured

The QIP consists of two primary components:

Core Measurement Set: evaluates provider performance across four domains:

- Clinical Quality
- Appropriate Use of Resources
- Access and Operations
- Patient Experience

Performance is measured across an eligible population. and incentive payments are tied to performance on these measures.

Unit of Service Measures: provide incentives for activities that support infrastructure development, quality improvement capacity, care coordination, and population health management. Examples include:

- Patient-Centered Medical Home (PCMH) certification
- Health Information Exchange (HIE) participation
- Health Equity planning
- Electronic Clinical Data System (ECDS) implementation
- Peer-Led Self-Management and Pediatric Group Visits
- Advanced Care Planning
- Academic Detailing

Together, these two components support both clinical outcomes and the systems needed to sustain improvement.

For the Core Measurement Set, performance is rewarded based on the **points earned** and the **number of member months** accumulated throughout the year. There is a per member per month (PMPM) amount for all sites. The number of member months is multiplied by the PMPM to determine the maximum amount an individual site can earn. That amount is then multiplied by the percentage of points earned through the Core Measurement Set to determine the actual incentive amount.

The Unit of Service measures, the payment is independent of and distinct from the financial incentives a site receives from the Core Measurement Set. A site receives payment according to the measure specifications if the **requirements for one or more Unit of Service measures are met**.

Clinical measures are tracked by eReports, an online system developed and maintained internally by Partnership. Functions offered in eReports to quality leaders include:

- Tracking clinical performance in real time
- Downloading patient reports for each of the clinical measures
- Uploading supplemental data for your patients

For information on how to create and eReports account and manage the site, please refer to the eReports User Manual on the [PHC Website](#). FQHC quality leaders should confirm measure definitions, thresholds, exclusions, and incentive rules against the current Partnership specifications for the applicable measurement year.

Points for clinical measures are determined by thresholds obtained by NCQA. The thresholds used typically include the 75th and 90th percentiles calculated from the previous year's HEDIS data. Health centers can earn points for relative improvement (without meeting the threshold) on a clinical measure by first meeting the 75th percentile performance target and demonstrating a minimum of 15% relative improvement.

Key Terms of the Partnership QIP

- **Eligible Population:** Assigned and/or Capitated Medi-Cal members, excludes Medi-Medi or members with other insurance primary, and Special Members.
- **Continuous Enrollment:** Members assigned for nine out of the 12 months between January 1 and December 31 of the reporting year. December is the anchor month. Applies to Clinical measures only.
- **Member Months (MM):** The sum of monthly enrollment counts over the course of the 12-month measurement period.
 - Example: If a site has 1,000 members each month, for the full measurement year the site has accumulated 12,000 member months
- **Per member per month (PMPM):** amount budgeted for the incentive payment
 - Note: PMPM amount may change annually based on the plan's financial performance. It is announced annually at the beginning of the measurement year and may change mid-year pending unforeseen State budget impacts to the plan.
- **Points Earned:** The total number of points earned out of the total available points across the Core Measurement Set. Total available points are 100.
- **Denominator:** The total number of persons during a defined time period who are eligible for the numerator event.
- **Numerator:** The number of persons in the denominator who received the appropriate preventive or diagnostic screening or test.

QIP Leader Takeaways

QIP should not be viewed solely as an incentive program.

Instead, quality leaders can use QIP as a strategic framework for identifying organizational priorities and focusing improvement efforts.

When developing a quality strategy:

- Prioritize measures that align across QIP, UDS, and HEDIS
- Use incentive opportunities that improve patient outcomes and support organizational improvement goals
- Monitor performance regularly to identify emerging gaps
- Develop multi-year strategies for clinical measure improvement

For many health centers, QIP provides a practical mechanism for translating quality goals into action. The most successful organizations organize their quality strategy around strengthening systems of care. Examples include:

- Improving preventive care outreach workflows
- Building robust care gap management processes
- Expanding population health management capabilities
- Strengthening health equity initiatives
- Developing data and reporting infrastructure

Viewed through this lens, QIP becomes more than an incentive program – it becomes a tool for building capacity for continuous improvement.

Resources

- QIP Website: <http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx>
- QIP Inbox: qip@partnershiphp.org
- eReports: <https://qip.partnershiphp.org/>

Facility Site Review (FSR)

Purpose

The Facility Site Review (FSR) is a regulatory and operational assessment conducted by Partnership HealthPlan of California (Partnership) and required by the California Department of Health Care Services (DHCS).

The purpose of the review is to ensure that provider organizations maintain the systems, policies, procedures, and clinical environments necessary to deliver safe, accessible, and high-quality care.

Unlike HEDIS, QIP, and UDS, which primarily focus on clinical performance and outcomes, the Facility Site Review focuses on the organizational infrastructure that supports quality care delivery.

Audience

The FSR is relevant to:

- Partnership HealthPlan of California
- Health center leadership
- Quality improvement teams
- Clinical and operational leaders

Why FSR Matters to Health Centers

Quality outcomes do not occur in isolation. Strong performance on preventive care, chronic disease management, and patient experience measures depends on reliable systems and operational processes.

The FSR evaluates whether those foundational systems are in place.

The FSR site reviews are conducted during the initial provider credentialing process. Additional site reviews will be conducted as part of the ongoing provider re-credentialing process at least every three years to assure that each provider continues to meet the standards set forth by local, state, and federal regulations.

The review assesses key operational areas including:

- Accessibility / Safety
- Office Management
- Personnel
- Clinical Services
- Preventive Services

- Infection Control

Viewed strategically, FSR helps organizations strengthen the operational foundation upon which quality efforts are built.

How Performance is Measured

The Site Review process includes three related components:

Facility Site Review: evaluates the physical environment, policies, procedures, equipment, and operational practices of the organization. Organizations are scored against DHCS-established standards and may be required to submit corrective action plans if deficiencies are identified.

Medical Records Review: evaluates the completeness and quality of clinical documentation. The areas being reviewed include format, documentation standards, continuity of care, pediatric and adult preventive care, and obstetrics/Comprehensive Perinatal Services Program (CPSP) preventive care. The review is particularly relevant to quality leaders because documentation practices directly influence performance on many HEDIS, UDS, and QIP measures.

Physical Accessibility Site Review: evaluates accessibility for patients with disabilities and seniors. Areas assessed include parking, building access, exam rooms, restrooms, and medical equipment accessibility. The review supports efforts to improve access to care and create more inclusive care environments.

QI Leader Takeaways

Quality leaders often focus on clinical performance measures such as blood pressure control or cancer screening. However, sustainable improvement requires strong operational systems.

When reviewing FSR findings, consider:

- Are documentation practices supporting accurate quality reporting?
- Are referral management processes functioning effectively?
- Are clinic workflows supporting preventive care delivery?
- Are staff training and competency processes adequate?
- Are there operational barriers that may be limiting quality performance?

FSR findings can provide valuable insights into root causes that may be contributing to performance challenges. While HEDIS, UDS, and QIP answer questions about outcomes and performance, FSR helps answer questions about operational reliability.

Uniform Data System (UDS)

Purpose

The Uniform Data System (UDS) is the national reporting system used by the Health Resources and Services Administration (HRSA) to monitor the performance of federally funded health centers.

UDS provides a standardized framework for reporting information about the patients served, services delivered, clinical quality outcomes, staffing, utilization, and financial performance of health centers across the country. HRSA's Bureau of Primary Health Care reports UDS data to the public through the website: <http://bphc.hrsa.gov/datareporting/index.html>.

The system allows HRSA, health centers, patients, policymakers, and other stakeholders to understand how health centers are performing and how effectively they are meeting the needs of their communities.

Audience

UDS data are used by:

- Health Resources and Services Administration (HRSA)
- Health center leadership
- Health center boards
- Quality improvement teams
- Policymakers
- Researchers

UDS provides one of the most comprehensive views of FQHC performance available.

Why UDS Matters to Health Centers

UDS provides a unique view of how effectively the health center delivers recommended care to patients who access services. The measure set provides a broad picture of organizational performance across multiple domains, including:

- Preventive care
- Chronic disease management
- Behavioral health integration
- Maternal and child health
- Health outcomes
- Health disparities

Many of the UDS measures also align with HEDIS and QIP requirements, creating opportunities for organizations to improve performance across multiple measurement systems through a single improvement effort.

How Performance is Measured

Health centers report UDS data annually in February based on services delivered during the prior calendar year.

The UDS report includes information across several major categories:

- Patient population and demographics
 - Patients by zip code
 - Patients by age and sex assigned at birth (Table 3A)
 - Demographic characteristics – ethnicity, race (Table 3B)
 - Select patient characteristics – income, insurance, managed care utilization, special populations (Table 4)
- Health center staffing and utilization (Table 5)
- Select diagnoses and services rendered (Table 6A)
- Quality of care measures (Table 6B)
- Health outcomes (Table 7)
- Financial costs (Table 8A)
- Patient related revenue (Table 9D)
- Other revenues (Table 9E)
- Appendix: Health center Health Information Technology (HIT) capabilities

UDS clinical quality measures are aligned with nationally recognized electronic clinical quality measures (eCQMs), Centers for Medicare & Medicaid Services (CMS) measures, and HEDIS specifications. This alignment helps reduce variation across reporting systems and creates greater consistency in quality measurement.

QI Leader Takeaways

Quality leaders should think of UDS as more than an annual reporting requirement.

UDS provides a valuable framework for understanding how well the organization is serving its patient population and where improvement efforts may have the greatest impact.

When reviewing UDS results, consider:

- Which measures align with health center priorities?
- Which measures overlap with HEDIS and QIP?
- Where are the largest performance gaps?
- Are there disparities in outcomes among patient populations?
- Which measure could benefit from focused improvement efforts?

Many health centers use UDS results to inform annual quality plans, strategic planning decisions, and Board-level quality reports.

Resources

- <http://www.bphc.hrsa.gov/datareporting/reporting/index.html>

From Measurement to Improvement: Understanding Measure Alignment and Improvement Strategy

After understanding the purpose of UDS, HEDIS, QIP, and Facility Site Review, the next step for quality leaders is understanding how these measurement systems work together.

Many of the measures included in these programs assess the same clinical topics, such as cancer screening, immunizations, chronic disease management, and depression screening. While these measures may appear similar, they are often measuring different patient populations and supporting different health center goals.

Understanding both the areas of alignment and the differences between measurement systems helps health centers develop more effective quality improvement strategies.

Measure Alignment Across Measurement Systems

The table below highlights the measures included in this toolkit and shows where they align across major reporting and incentive programs.

Themes	Measure Name	FSR	HEDIS	PCP QIP	UDS
Primary Preventive	Cervical Cancer Screening	X	X	X	X
	Breast Cancer Screening	X	X	X	X
	Colorectal Cancer Screening	X	X	X	X
	Prenatal & Postpartum Care - Timeliness of Prenatal Care	X	X	X	X
	Prenatal & Postpartum Care - Postpartum Care		X		
	Birth Weight of Infants				X
	Depression Screening	X			X
	Depression Remission				X
	Dental Sealants	X	X		X
Immunizations	Childhood Immunization Combination 10	X	X	X	X
	Immunizations for Adolescents	X	X	X	
Chronic Disease Management	Diabetes Care - Retinal Eye Exam			X	
	Diabetes Care - HbA1c Control		X	X	X
	Complete Lipid panel	X			
	Hypertension- Controlling High Blood Pressure	X	X	X	X
	Tobacco Use and Cessation	X			X
	HIV Screening				X
	HIV Linkages to Care				X
	Adult Weight Screening and Follow-Up	X			X
Well Child Checks	WCC-BMI	X			X
	Well Child 3-6 Years	X			
	Well Child First 15 Months of Life	X	X	X	
	Child and Adolescent Well Care	X	X	X	
	Lead Screening in Children	X	X	X	
Medication Management	Asthma Medications		X		
	Statin Therapy				X
	Ischemic Vascular Disease (IVD): Aspirin or Anti Thrombotic Therapy				X

* Refer to the full Measure Alignment Crosswalk ([link](#)) for detailed measure specifications and program requirements.

Similar Measures, Different Improvement Strategies

One of the most important concepts for quality leaders is recognizing that measures may align across programs while requiring different improvement approaches. Although many measures appear in UDS, QIP and HEDIS, the populations being measured may be different.

HEDIS and QIP: A Population Health Perspective

HEDIS and QIP primarily evaluate care provided to assigned PHC members. These systems ask:

“How effectively are we managing the health of the population for which we are accountable?”

Success depends on identifying patients who may not be actively seeking care and proactively closing care gaps across the assigned population.

Common quality improvement questions include:

- Which assigned members have care gaps?
- Who is overdue for preventive services?
- Which patients are not engaging in care?
- How effectively are we reaching patients who have not been seen recently?
- Are our outreach and recall systems working?

For many measures the greatest improvement opportunities occur outside the patient visit.

UDS: A Care Delivery Perspective

UDS primarily evaluates care delivered to patients who received services from the health center during the reporting period.

UDS asks the question:

“When patients come to us for care, are we consistently delivering recommended services?”

Success depends on ensuring that every visit is used as an opportunity to provide evidence-based preventive care and chronic disease management.

Common quality improvement questions include:

- Are patients with care gaps being identified during visits?
- Are recommended screenings being offered routinely?
- Are care teams consistently following established workflows?
- Where are missed opportunities occurring?
- Are documentation practices accurately capturing care delivered?

For many UDS measures, the greatest opportunity for improvement occurs in pre-visit planning and during the patient encounter.

Strategic Insight: One Measure, Two Perspectives

Consider colorectal cancer screening.

HEDIS / QIP Perspective <i>Focus is on assigned members</i>	UDS Perspective <i>Focus is on care delivery during visits</i>
Which assigned members are overdue? Have we contacted them? Are outreach efforts effective? Are screening kits being returned?	Are eligible patients being identified prior to or during visits? Are providers recommending screening? Are referrals being placed and tracked? Are opportunities for screening being missed?

Both perspectives are important. Health centers that perform well on quality measures typically combine strong population health management strategies with reliable care delivery processes.