Performance Evaluation Report

Anthem Blue Cross Partnership Plan

July 1, 2010–June 30, 2011

Medi-Cal Managed Care Division
California Department of
Health Care Services

June 2012

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4.3 million beneficiaries (as of June 2011)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to the domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, Anthem Blue Cross Partnership Plan ("Anthem" or "the plan"), which delivers care in Alameda, Contra Costa, Fresno, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare counties, for the review period July 1, 2010, through June 30, 2011. Actions taken by the plan subsequent to June 30, 2011, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

Anthem Blue Cross, formerly Blue Cross of California prior to April 1, 2008, is a full-scope Medi-Cal managed care plan operating in nine counties: Alameda, Contra Costa, Fresno, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.

Anthem delivers care to members using the Two-Plan model for some counties and the Geographic Managed Care (GMC) model for one county. In a Two-Plan model county, the DHCS contracts with two managed care plans to provide health care services to members. In most Two-Plan model counties, Medi-Cal beneficiaries in both mandatory and voluntary aid codes can choose between a local initiative (LI) plan and a nongovernmental commercial health plan. Anthem delivers care to members as a commercial plan in Alameda, Contra Costa, Fresno, San Francisco, San Joaquin, and Santa Clara counties. It delivers care as an LI in Stanislaus and Tulare counties. In Sacramento County, Anthem serves members under a GMC model. In the GMC model, Medi-Cal beneficiaries in both mandatory and voluntary aid codes can choose between several commercial plans within a specified county.

As of March 1, 2011, Anthem contracted with the DHCS to serve members in Fresno County under a new contract. The new contract was part of a Medi-Cal managed care expansion project, which also allowed the plan to serve members as of March 1, 2011, in Kings and Madera counties; however, the DHCS will not require the plan to report QIP or performance measure data until the plan has been operational in Kings and Madera counties for one year. Anthem serves members in Fresno, Kings, and Madera counties under the Two-Plan model.

Anthem initiated services under the MCMC Program in Sacramento County in 1994, then expanded into its additional contracted counties. As of June 30, 2011, Anthem had 435,686 enrolled members under the MCMC Program for all of its contracted counties combined.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2011*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan'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 standards.

The DHCS conducts this review activity through an extensive monitoring process that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

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

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division have historically worked in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits have been conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

HSAG reviewed the most current medical performance audit reports available as of June 30, 2011, to assess plans' compliance with State-specified standards. The most recent audit for Anthem was conducted by A&I in tandem with MMCD in September 2009, covering the review period of August 1, 2008, through July 31, 2009. HSAG reported the detailed findings from this audit in the July 1, 2009–June 30, 2010 evaluation report.[3] The audit covered the areas of utilization management, continuity of care, access and availability, member rights, quality management, and administrative and organizational capacity. Many areas of strength were identified and several deficiencies were noted.

As noted in the July 1, 2009–June 30, 2010 evaluation report, a DHCS medical audit letter was issued to Anthem in response to its corrective action plan to address the deficiencies identified in the joint audit. While it was noted that several areas had been adequately addressed by the plan, eight outstanding deficiencies remained.

Also noted in the previous evaluation report, a *Medical Audit Close-Out Report* issued by the DHCS on September 14, 2010, indicated that the plan adequately addressed four areas including utilization management, continuity of care, member rights, and administrative and organizational capacity; however, the plan remained noncompliant in specific areas of monitoring appointment wait times, time and distance standards for primary care providers in Contra Costa County, oversight of hospitals to ensure access to medications in emergency situations, and adequate review of member grievances involving potential quality-of-care issues.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These member rights reviews are conducted before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2011.

[3] *Performance Evaluation Report – Anthem Blue Cross, July 1, 2009 – June 30, 2010.* California Department of Health Care Services. September 2011. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

The most current MRPIU review of Anthem was conducted in May 2009, covering the review period of July 1, 2007, through December 31, 2008. HSAG included the details of this review in the July 1, 2008–June 30, 2009 evaluation report,[4] which indicated that MRPIU noted review findings in these areas: member grievances, prior authorization notification, and cultural and linguistic services.

Regarding member grievances, Anthem's policies did not include information for addressing cultural and linguistic requirements for processing grievances.

In the area of prior authorization notification, it was noted that the policies and procedures submitted did not include the required record retention time frame. Also, six of 40 case files reviewed at the Physicians Medical Group of San Jose, a Blue Cross subcontracted entity, contained a "Your Rights" attachment that made reference to the Santa Clara Family Health Plan instead of Anthem Blue Cross. The third finding under prior authorization was that the notice of action (NOA) letter in one out of two prior authorization files reviewed at Children's First Medical Group, a Blue Cross subcontracted entity, was missing the required reason supporting the action taken.

In the category of cultural and linguistic services, the MRPIU revealed three findings:

(1) The policies and procedures that were submitted did not include that limited English proficient (LEP) members will not be subjected to unreasonable delays in receiving appropriate interpreter services when the need for such services is identified by the provider or requested by the LEP member.

(2) It was noted through a field visit that staff members of two providers' offices stated that if a member called the office after hours, the telephone message was in English or Spanish only.

(3) It was also noted through a field visit to a provider's office that members are encouraged to use family/friends as interpreters.

Strengths

As stated in the prior year's evaluation report,[5] Anthem adequately addressed four areas in which it was found to be deficient when audited by A&I and MMCD in September 2009. In May 2009, MRPIU also found the plan to be in full compliance over its marketing requirements.

[4] *Performance Evaluation Report – Anthem Blue Cross, July 1, 2008 – June 30, 2009*. California Department of Health Care Services. September 2011. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

[5] *Performance Evaluation Report – Anthem Blue Cross, July 1, 2009 – June 30, 2010*. California Department of Health Care Services. September 2011. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

Opportunities for Improvement

After review, the plan's *2010 Quality Improvement Work Plan* does not appear to include activities to specifically address areas of outstanding deficiencies. The areas in which Anthem is noncompliant could significantly affect members' access to quality, timely, and culturally relevant services. It is important that Anthem identify ways to address the deficiencies, including the implementation of monitoring activities to ensure opportunities for improvements are identified and the goals are met.

Conducting the Review

The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provide a standardized method for objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about Anthem's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2011 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures; therefore, HSAG performed a HEDIS Compliance Audit™ of Anthem in 2011 to determine whether the plan followed the appropriate specifications to produce valid rates. The audit found all 2011 performance measures rates to be reportable; however, there were several observations and recommendations made. The audit team noted that, based on concerns related to encounter data completeness in the prior year, documentation provided on-site showed that Anthem had implemented a formal monitoring data completeness committee although this committee had not been fully implemented for the 2010 measurement year. The plan had some issues with incomplete encounter data submissions from one large medical group which were not resolved until after the reporting period. Additionally the audit team recommended that the plan

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

explore using PM-160 data as a supplemental data source that may improve rates for several measures. Finally, due to the size and multiple locations of Anthem staff, the auditors recommended that Anthem create documentation of its HEDIS data workflow specific to the Medi-Cal managed care line of business to identify staff members for key stakeholders responsible for the various aspects of HEDIS reporting.

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Table 3.2.

Table 3.1—HEDIS® 2011 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2011 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Tables 3.2 through 3.10 present a summary of Anthem's HEDIS 2011 performance measure results (based on calendar year [CY] 2010 data) compared to HEDIS 2010 performance measure results (based on CY 2009 data). To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a

high performance level (HPL) for each measure. The table shows the plan's HEDIS 2011 performance compared to the MCMC-established MPLs and HPLs.

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

Table 3.2—2010–2011 Performance Measure Results for Anthem Blue Cross—Alameda County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	32.0%	34.3%	★★	↔	19.7%	35.9%
AWC	Q,A,T	26.5%	32.8%	★	↑	38.8%	63.2%
BCS	Q,A	47.3%	46.8%	★★	↔	46.2%	63.8%
CCS	Q,A	61.6%	54.0%	★	↓	61.0%	78.9%
CDC–BP	Q	40.1%	50.6%	★	↑	53.5%	73.4%
CDC–E	Q,A	32.4%	28.0%	★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	34.5%	37.7%	★	↔	38.7%	58.8%
CDCH9 (>9.0%)	Q	33.8%	53.5%	★★	↓	53.4%	27.7%
CDC–HT	Q,A	72.5%	72.7%	★	↔	76.0%	90.2%
CDC–LC (<100)	Q	22.1%	29.2%	★★	↑	27.2%	45.5%
CDC–LS	Q,A	63.7%	68.4%	★	↔	69.3%	84.0%
CDC–N	Q,A	65.9%	68.9%	★	↔	72.5%	86.2%
CIS–3	Q,A,T	54.3%	66.9%	★★	↑	63.5%	82.0%
LBP	Q	86.4%	86.9%	★★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	75.9%	65.9%	★	↓	80.3%	92.7%
PPC–Pst	Q,A,T	43.3%	51.1%	★	↑	58.7%	74.4%
URI	Q	92.5%	94.9%	★★★	↑	82.1%	94.9%
W34	Q,A,T	54.0%	62.0%	★	↑	65.9%	82.5%
WCC–BMI	Q	23.4%	47.0%	★★	↑	13.0%	63.0%
WCC–N	Q	33.3%	55.2%	★★	↑	34.3%	67.9%
WCC–PA	Q	20.4%	28.5%	★★	↑	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.3—2010–2011 Performance Measure Results for Anthem Blue Cross—Contra Costa County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	42.9%	30.0%	★★	↔	19.7%	35.9%
AWC	Q,A,T	21.2%	26.8%	★	↔	38.8%	63.2%
BCS	Q,A	42.9%	37.1%	★	↔	46.2%	63.8%
CCS	Q,A	55.0%	53.0%	★	↔	61.0%	78.9%
CDC–BP	Q	39.8%	55.2%	★★	↑	53.5%	73.4%
CDC–E	Q,A	23.1%	26.4%	★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	25.9%	35.2%	★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	34.3%	58.4%	★	↓	53.4%	27.7%
CDC–HT	Q,A	66.7%	69.6%	★	↔	76.0%	90.2%
CDC–LC (<100)	Q	19.4%	26.4%	★	↔	27.2%	45.5%
CDC–LS	Q,A	63.9%	61.6%	★	↔	69.3%	84.0%
CDC–N	Q,A	63.0%	66.4%	★	↔	72.5%	86.2%
CIS–3	Q,A,T	48.9%	68.6%	★★	↑	63.5%	82.0%
LBP	Q	82.4%	85.9%	★★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	66.1%	69.4%	★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	28.8%	43.5%	★	↑	58.7%	74.4%
URI	Q	91.2%	90.3%	★★	↔	82.1%	94.9%
W34	Q,A,T	37.0%	63.3%	★	↑	65.9%	82.5%
WCC–BMI	Q	33.8%	49.1%	★★	↑	13.0%	63.0%
WCC–N	Q	36.7%	52.8%	★★	↑	34.3%	67.9%
WCC–PA	Q	29.2%	35.3%	★★	↔	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.4—2010–2011 Performance Measure Results for Anthem Blue Cross—Fresno County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	32.3%	30.7%	★★	↔	19.7%	35.9%
AWC	Q,A,T	40.9%	33.3%	★	↓	38.8%	63.2%
BCS	Q,A	40.8%	37.3%	★	↓	46.2%	63.8%
CCS	Q,A	65.9%	59.6%	★	↔	61.0%	78.9%
CDC–BP	Q	56.7%	59.3%	★★	↔	53.5%	73.4%
CDC–E	Q,A	41.4%	34.9%	★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	38.7%	36.1%	★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	29.2%	54.4%	★	↓	53.4%	27.7%
CDC–HT	Q,A	76.9%	79.8%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	28.2%	28.0%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	75.7%	75.1%	★★	↔	69.3%	84.0%
CDC–N	Q,A	76.9%	79.0%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	66.2%	60.3%	★	↔	63.5%	82.0%
LBP	Q	82.6%	80.6%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	85.2%	70.6%	★	↓	80.3%	92.7%
PPC–Pst	Q,A,T	55.7%	50.9%	★	↔	58.7%	74.4%
URI	Q	87.1%	86.0%	★★	↓	82.1%	94.9%
W34	Q,A,T	69.3%	73.7%	★★	↔	65.9%	82.5%
WCC–BMI	Q	51.3%	47.2%	★★	↔	13.0%	63.0%
WCC–N	Q	61.6%	53.0%	★★	↓	34.3%	67.9%
WCC–PA	Q	39.9%	36.3%	★★	↔	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.5—2010–2011 Performance Measure Results for Anthem Blue Cross—Sacramento County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	30.9%	23.1%	★★	↓	19.7%	35.9%
AWC	Q,A,T	36.5%	28.7%	★	↓	38.8%	63.2%
BCS	Q,A	38.4%	37.1%	★	↔	46.2%	63.8%
CCS	Q,A	58.4%	61.8%	★★	↔	61.0%	78.9%
CDC–BP	Q	50.4%	55.0%	★★	↔	53.5%	73.4%
CDC–E	Q,A	30.9%	28.2%	★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	45.7%	43.6%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	47.7%	47.9%	★★	↔	53.4%	27.7%
CDC–HT	Q,A	71.8%	76.4%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	22.9%	29.7%	★★	↑	27.2%	45.5%
CDC–LS	Q,A	65.0%	64.5%	★	↔	69.3%	84.0%
CDC–N	Q,A	63.3%	72.0%	★	↑	72.5%	86.2%
CIS–3	Q,A,T	53.0%	57.7%	★	↔	63.5%	82.0%
LBP	Q	83.9%	83.7%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	71.8%	70.3%	★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	52.1%	49.9%	★	↔	58.7%	74.4%
URI	Q	93.8%	94.3%	★★	↔	82.1%	94.9%
W34	Q,A,T	70.3%	73.7%	★★	↔	65.9%	82.5%
WCC–BMI	Q	33.6%	49.9%	★★	↑	13.0%	63.0%
WCC–N	Q	42.3%	59.6%	★★	↑	34.3%	67.9%
WCC–PA	Q	27.5%	27.7%	★★	↔	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.6—2010–2011 Performance Measure Results for Anthem Blue Cross—San Francisco County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	52.1%	50.0%	★★★	↔	19.7%	35.9%
AWC	Q,A,T	53.8%	55.7%	★★	↔	38.8%	63.2%
BCS	Q,A	60.3%	58.3%	★★	↔	46.2%	63.8%
CCS	Q,A	70.1%	74.5%	★★	↔	61.0%	78.9%
CDC–BP	Q	68.6%	75.4%	★★★	↔	53.5%	73.4%
CDC–E	Q,A	46.7%	46.3%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	56.7%	55.7%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	18.6%	32.5%	★★	↓	53.4%	27.7%
CDC–HT	Q,A	84.3%	84.2%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	35.7%	36.0%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	77.1%	75.4%	★★	↔	69.3%	84.0%
CDC–N	Q,A	82.9%	81.8%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	75.2%	79.1%	★★	↔	63.5%	82.0%
LBP	Q	77.4%	85.4%	★★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	90.4%	88.0%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	57.4%	55.5%	★	↔	58.7%	74.4%
URI	Q	95.3%	96.1%	★★★	↔	82.1%	94.9%
W34	Q,A,T	81.5%	76.4%	★★	↔	65.9%	82.5%
WCC–BMI	Q	59.1%	53.5%	★★	↔	13.0%	63.0%
WCC–N	Q	69.6%	70.8%	★★★	↔	34.3%	67.9%
WCC–PA	Q	52.1%	56.2%	★★	↔	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.7—2010–2011 Performance Measure Results for Anthem Blue Cross—San Joaquin County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	21.5%	8.8%	★	↓	19.7%	35.9%
AWC	Q,A,T	41.4%	41.1%	★★	↔	38.8%	63.2%
BCS	Q,A	47.1%	44.4%	★	↔	46.2%	63.8%
CCS	Q,A	58.9%	61.6%	★★	↔	61.0%	78.9%
CDC–BP	Q	50.7%	56.7%	★★	↔	53.5%	73.4%
CDC–E	Q,A	36.1%	37.7%	★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	34.4%	35.5%	★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	34.2%	57.4%	★	↓	53.4%	27.7%
CDC–HT	Q,A	75.0%	77.9%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	24.0%	28.7%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	72.8%	72.5%	★★	↔	69.3%	84.0%
CDC–N	Q,A	75.7%	76.9%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	69.1%	64.5%	★★	↔	63.5%	82.0%
LBP	Q	79.8%	76.4%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	84.9%	79.3%	★	↓	80.3%	92.7%
PPC–Pst	Q,A,T	48.9%	51.3%	★	↔	58.7%	74.4%
URI	Q	84.7%	87.1%	★★	↑	82.1%	94.9%
W34	Q,A,T	78.3%	74.9%	★★	↔	65.9%	82.5%
WCC–BMI	Q	55.5%	49.9%	★★	↔	13.0%	63.0%
WCC–N	Q	60.6%	70.6%	★★★	↑	34.3%	67.9%
WCC–PA	Q	20.2%	28.7%	★★	↑	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.8—2010–2011 Performance Measure Results for Anthem Blue Cross—Santa Clara County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	26.7%	28.8%	★★	↔	19.7%	35.9%
AWC	Q,A,T	48.7%	44.3%	★★	↔	38.8%	63.2%
BCS	Q,A	69.6%	67.1%	★★★	↔	46.2%	63.8%
CCS	Q,A	71.3%	72.0%	★★	↔	61.0%	78.9%
CDC–BP	Q	66.4%	72.5%	★★	↔	53.5%	73.4%
CDC–E	Q,A	53.5%	53.8%	★★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	50.1%	60.1%	★★★	↑	38.7%	58.8%
CDC–H9 (>9.0%)	Q	22.6%	31.9%	★★	↓	53.4%	27.7%
CDC–HT	Q,A	81.3%	87.3%	★★	↑	76.0%	90.2%
CDC–LC (<100)	Q	36.0%	46.7%	★★★	↑	27.2%	45.5%
CDC–LS	Q,A	81.8%	84.7%	★★★	↔	69.3%	84.0%
CDC–N	Q,A	78.1%	83.0%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	64.2%	70.6%	★★	↔	63.5%	82.0%
LBP	Q	80.1%	83.9%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	79.1%	83.5%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	55.5%	65.7%	★★	↑	58.7%	74.4%
URI	Q	91.5%	92.2%	★★	↔	82.1%	94.9%
W34	Q,A,T	74.9%	70.1%	★★	↔	65.9%	82.5%
WCC–BMI	Q	56.0%	65.7%	★★★	↑	13.0%	63.0%
WCC–N	Q	55.0%	63.5%	★★	↑	34.3%	67.9%
WCC–PA	Q	55.0%	35.5%	★★	↓	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.9—2010–2011 Performance Measure Results for Anthem Blue Cross—Stanislaus County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	22.0%	24.9%	★★	↔	19.7%	35.9%
AWC	Q,A,T	34.3%	29.9%	★	↔	38.8%	63.2%
BCS	Q,A	50.8%	51.3%	★★	↔	46.2%	63.8%
CCS	Q,A	67.9%	67.2%	★★	↔	61.0%	78.9%
CDC–BP	Q	56.6%	57.7%	★★	↔	53.5%	73.4%
CDC–E	Q,A	38.5%	22.4%	★	↓	41.4%	70.1%
CDC–H8 (<8.0%)	Q	43.2%	34.1%	★	↓	38.7%	58.8%
CDC–H9 (>9.0%)	Q	30.0%	58.4%	★	↓	53.4%	27.7%
CDC–HT	Q,A	80.5%	76.2%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	29.8%	24.8%	★	↔	27.2%	45.5%
CDC–LS	Q,A	78.0%	72.3%	★★	↔	69.3%	84.0%
CDC–N	Q,A	75.6%	71.3%	★	↔	72.5%	86.2%
CIS–3	Q,A,T	65.2%	58.9%	★	↔	63.5%	82.0%
LBP	Q	81.5%	79.5%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	86.1%	84.6%	★★	↔	80.3%	92.7%
PPC–Pst	Q,A,T	54.3%	53.7%	★	↔	58.7%	74.4%
URI	Q	92.0%	92.0%	★★	↔	82.1%	94.9%
W34	Q,A,T	66.7%	69.3%	★★	↔	65.9%	82.5%
WCC–BMI	Q	34.5%	33.1%	★★	↔	13.0%	63.0%
WCC–N	Q	40.9%	45.0%	★★	↔	34.3%	67.9%
WCC–PA	Q	20.2%	23.1%	★★	↔	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Table 3.10—2010–2011 Performance Measure Results for Anthem Blue Cross—Tulare County

Performance Measure[1]	Domain of Care[2]	2010 HEDIS Rates[3]	2011 HEDIS Rates[4]	Performance Level for 2011	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	23.6%	15.8%	★	↓	19.7%	35.9%
AWC	Q,A,T	29.9%	35.8%	★	↔	38.8%	63.2%
BCS	Q,A	51.2%	48.4%	★★	↔	46.2%	63.8%
CCS	Q,A	71.0%	67.2%	★★	↔	61.0%	78.9%
CDC–BP	Q	63.5%	65.0%	★★	↔	53.5%	73.4%
CDC–E	Q,A	27.7%	29.2%	★	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	43.1%	42.1%	★★	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	27.3%	49.6%	★★	↓	53.4%	27.7%
CDC–HT	Q,A	76.6%	77.1%	★★	↔	76.0%	90.2%
CDC–LC (<100)	Q	29.4%	31.9%	★★	↔	27.2%	45.5%
CDC–LS	Q,A	72.5%	69.8%	★★	↔	69.3%	84.0%
CDC–N	Q,A	74.7%	76.9%	★★	↔	72.5%	86.2%
CIS–3	Q,A,T	68.1%	69.1%	★★	↔	63.5%	82.0%
LBP	Q	78.1%	79.6%	★★	↔	72.0%	84.1%
PPC–Pre	Q,A,T	74.0%	82.7%	★★	↑	80.3%	92.7%
PPC–Pst	Q,A,T	46.5%	64.0%	★★	↑	58.7%	74.4%
URI	Q	83.7%	84.1%	★★	↔	82.1%	94.9%
W34	Q,A,T	60.1%	73.2%	★★	↑	65.9%	82.5%
WCC–BMI	Q	43.8%	32.6%	★★	↓	13.0%	63.0%
WCC–N	Q	48.7%	48.9%	★★	↔	34.3%	67.9%
WCC–PA	Q	39.4%	30.2%	★★	↓	22.9%	56.7%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.
[4] HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, Anthem had below-average to average performance across the various counties, which was consistent with 2010's results. Thirty-two percent of the measures across all counties fell below the MPLs, and only 7 percent of the measures came in above the HPLs. Despite the low rates, the plan was able to report valid rates for all measures across all counties.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan. For each area of deficiency, the plan must outline steps to improve care.

For measures requiring a 2010 improvement plan, HSAG used 2011 HEDIS scores to evaluate progress during the year. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or develop new improvement plans.

Across all counties Anthem had 51 measures that fell below the MPLs in 2010, resulting in a total of 12 different improvement plans (improvement plans contained multiple counties, if applicable). The measures that performed below the MPLs and required an improvement plan in 2011 were: *Adolescent Well-Care Visits, Breast Cancer Screening, Cervical Cancer Screening, Comprehensive Diabetes Care—Eye Exam (Retinal) Performed, 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, Childhood Immunization Status—Combination 3, Prenatal and Postpartum Care—Timeliness of Prenatal Care, Prenatal and Postpartum Care—Postpartum Care,* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.*

Adolescent Well-Care Visits

Overall, five out of nine counties (55 percent) performed below the MPL for this measure in 2010 and were required to submit improvement plans.

The plan conducted a barrier analysis and identified the following as barriers to performance:

- Patient and parent lack of knowledge of need for preventive care.
- In 2010, new HEDIS software was implemented. It should be noted that it is possible that this system change created an internal threat to the validity of the results. The plan's HEDIS team has actively analyzed and created an intervention plan for identified issues.
- Infrequent preventive visits in this age group may use alternative sites for health care visits, such as family planning clinics.

The plan's improvement plan lists on-going interventions for counties with poor past performance as well as interventions for counties that fell below the MPL in 2010. All five counties that conducted improvement plans in 2010 from 2009's results continued to perform below the MPL. In addition, Fresno County's performance on this measure fell from average to below average from 2010 to 2011. Anthem Blue Cross will need to address poor *AWC* rates in its upcoming CAP.

Cancer Screening

Anthem continued efforts to improve performance on both *Breast Cancer and Cervical Cancer Screening* measures in 2010.

The plan implemented the following interventions, which included, but were not limited to:

- Providing automated reminder calls and reminder cards to members whose claims data indicated that they needed a mammogram.
- Distributing lists of members in need of the screening to providers.
- Posting screening locations on Anthem's Web site.
- Creating a member newsletter article.
- Distributing preventive health guidelines to providers and members.

Contra Costa, Fresno, and Sacramento counties were all required to submit improvement plans for *Breast Cancer Screening* for 2010 measures. Contra Costa County has scored below the MPL for several consecutive years and actually decreased in performance in 2011 even after the improvement efforts. San Joaquin's performance on this measure fell from average to below average from 2010 to 2011, although the overall change between these years was not statistically significant.

Anthem's rate for the *Cervical Cancer Screening* measure in Contra Costa, Sacramento, and San Joaquin counties also required an improvement plan. The plan conducted automated calls to members in need of a screening twice per year and distributed toolkits and member listings to providers. For 2011 results, Contra Costa continued to drop in performance even though it has been heavily involved in improvement efforts; and Alameda's and Fresno's performance for the *CCS* measure fell from average to below average from 2010 to 2011. Sacramento and San Joaquin counties were able to raise their 2011 score above the MPL.

Well-Visits for Children and Adolescents

Alameda and Contra Costa counties performed below the MPL for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure for the second consecutive year; however, both showed statistically significant improvement from 2010 to 2011, which might indicate that interventions to improve performance on this measure are proving to be successful. Tulare County performed below the MPL in 2010 but improved to average performance in 2011, which might also be an indication of successful intervention efforts.

Anthem identified several barriers that affect the well-visits measure performance. Among them were:

- Physician access to data on percentage of patients in practice with well visits/vaccines.
- Identification of missed opportunities.
- Providers' need to emphasize value of well-child visits and scope of evaluation.
- Physician knowledge gap on best practice recommendations using national data, published research studies, and professional guidelines.

To address these barriers, the plan implemented interventions, which included:

- Automated reminder calls in English and Spanish.
- Reminder postcards.
- Distribution of member lists, toolkits, and guidelines to providers.
- A member newsletter.

Since Alameda and Contra Costa counties showed statistically significant increases in their performance for this measure from 2010 to 2011, it is important that Anthem assess which intervention efforts have contributed to the improvement so that continued success can be realized. The plan might also benefit from assessing which intervention efforts contributed to Tulare's ability to improve performance from below average to average from 2010 to 2011.

Childhood Immunizations

Three counties (Alameda, Contra Costa, and Sacramento) performed below the MPL in 2010 for *Childhood Immunization Status—Combination 3* and were thus required to submit performance improvement plans. Anthem's improvement plan was effective for Alameda and Contra Costa Counties, as both were able to increase their rates to above the MPL; however, Sacramento County's rate for this measure remaining below the MPL in 2011. Fresno experienced a statistically significant decrease in performance for this measure from 2009 to 2010; and, although the decrease in performance from 2010 to 2011 was not statistically significant, it was enough to

lower Fresno's performance from average to below average. Stanislaus County's performance for this measure also fell from average in 2010 to below average in 2011.

To improve childhood immunization rates, Anthem:

- Conducted automated calls.
- Sent out reminder postcards.
- Distributed provider toolkits, preventive health guidelines, and listings of members in need of vaccinations.
- Conducted reminder calls to new mothers to remind them of the importance of immunizations.

The plan conducted additional analysis and found statistically significant differences based on both language and ethnicity in Alameda and Contra Costa counties. The plan found success with this analysis, as both of the aforementioned counties improved their measures. Ongoing efforts to improve performance for this measure will need to continue since three counties are performing below the MPL.

Prenatal and Postpartum Care

Anthem continues to struggle with prenatal and postpartum care performance measure rates, similar to the prior year's findings. The plan had rates below the MPL for prenatal care in 2009 in Sacramento and Santa Clara counties. In 2010 Alameda, Contra Costa, Sacramento, and Tulare counties all fell below the MPL. Three of these counties fell below the MPL for prenatal care in 2011; and two more counties, Fresno and San Joaquin, fell from average performance in 2010 to below-average performance in 2011 for this measure. Tulare County improved its performance to above the MPL for prenatal care in 2011. For postpartum care, four counties in 2009 required an improvement plan: Alameda, Contra Costa, San Joaquin, and Stanislaus. In 2010, all nine of Anthem's counties fell below the MPL for postpartum care. In 2011, Santa Cara and Tulare experienced a statistically significant increase in their performance, which resulted in them moving from below-average to average performance on this measure. All other counties (Alameda, Contra Costa, Fresno, Sacramento, San Francisco, San Joaquin, and Stanislaus) continued to perform below the MPL in 2011.

Anthem identified several barriers that affect prenatal and postpartum care measure performance. Among them were:

- Lack of member awareness about the importance of care.
- Lack of adequate incentives for participation in the prenatal program or to keep postpartum care appointments.
- Physicians may not have a tracking system for ensuring women are seen on schedule for postpartum check-ups.

To address these barriers, Anthem:

- Sent out educational packets.
- Screened pregnant members for referral to case management.
- Distributed toolkits and perinatal guidelines to providers.
- Encouraged the use of a Pregnancy Notification form by providers to notify the plan of newly pregnant members.

The prenatal care interventions were effective in Santa Clara County, but Sacramento County remained below the MPL; and additional counties experienced low performance for this measure in 2010 and 2011. The plan identified that a major barrier to improvement was the lack of early identification of pregnant members.

Anthem's interventions to improve postpartum care were similar to those implemented for prenatal care, with some additional activities, including reminder calls, gift cards for members who attend the postpartum visit, and distribution of transportation information to both members and providers. All four counties that performed below the MPL in 2009 remained below the MPL in 2010; these four counties were joined by Fresno, Sacramento, San Francisco, Santa Clara, and Tulare counties. The 2011 HEDIS rates show continued poor performance for the four counties that performed below the MPL in 2009, along with three additional counties that show poor performance for two consecutive years (Fresno, Sacramento, and San Francisco). Anthem will need to continue its efforts to identify and implement interventions that will improve its performance on the postpartum care measure.

Diabetes Care

Anthem was required to develop HEDIS improvement plans for at least one diabetes measure in all counties except San Francisco and Santa Clara. The plan identified barriers and challenges related to diabetes care management, which included:

- Members' lack of education about the disease.
- Low literacy.
- Denial.
- Transportation issues.
- Frequent PCP changes.
- Lack of specialty care.
- Appointment availability.
- Language issues.
- Lack of knowledge of or adherence to clinical guidelines.

Anthem used a macro approach to improving each indicator through its existing diabetes program. Interventions targeting members included outreach calls, distribution of diabetes management educational materials and educational calendars, automated screening reminder calls, and case management outreach screening scripts. Provider interventions included distributing lists of members in need of specific screenings, toolkits, diabetes clinical practice guidelines, and member-specific provider notices, which included reminders for upcoming screenings and data on utilization of services.

The improvement plans yielded mixed results; but on the whole, they have not been able to significantly increase the diabetes measures for Anthem Blue Cross. Several of the counties are in the midst of ongoing improvement plans that have not yielded the intended results.

Strengths

HSAG identified some notable strengths across all counties for Anthem. In 2011, the plan exceeded the MPLs across all its counties for *Use of Imaging Studies for Low Back Pain*, *Appropriate Treatment for Children With Upper Respiratory Infection, BMI Assessment, Nutrition Counseling,* and *Physical Activity Counseling.* In fact, three counties finished above the HPL for *Use of Imaging Studies for Low Back Pain.* Santa Clara was the top-performing county with five rates above the HPL and zero rates below the MPL.

Opportunities for Improvement

Anthem's largest opportunities for improvement lie in the diabetes and prenatal/postpartum care domains. For the second consecutive year *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* was one of the lowest scoring measures with seven out of nine plans scoring below the MPL. Other measures that needed focused improvement efforts included *Adolescent Well-Care Visits*, *Breast Cancer Screening,* and *Cervical Cancer Screening.*

Three counties had substantial opportunities for improvement. Alameda, Contra Costa, and Fresno reported eleven, thirteen and nine rates below the MPLs, respectively, as noted in Tables 3.2, 3.3, and 3.4.

Due to Anthem's ongoing poor performance for many counties, the DHCS required Anthem to develop a formal corrective action plan (CAP) in April 2011; and in an e-mail message to HSAG dated December 29, 2011, the DHCS indicated that it accepted Anthem's CAP and decided that the plan was not required to submit HEDIS improvement plans for 2010 rates because of the existence of the CAP. If the HEDIS rates that fall under the CAP do not improve in 2012, reflecting the 2011 calendar year measurement period, then the situation will need to be further assessed to determine how to address the plan's continued poor performance. Although the most recent version of the CAP was developed in July 2011, which falls outside the dates covered in

this evaluation report, HSAG determined that it was important to review the CAP and consider the information contained in it when making recommendations.

The plan has an opportunity to focus its effort on the corrective action plan and ensure adequate resources are devoted to Medi-Cal managed care members at the county level.

Conducting the Review

The purpose of a quality improvement project (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 Centers for Medicare & Medicaid Services' (CMS') validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2010–June 30, 2011*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

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

Quality Improvement Projects Conducted

Anthem had two clinical QIPs in progress during the review period of July 1, 2010–June 30, 2011. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS' statewide collaborative QIP project. Anthem's second project, an internal QIP, aimed at improving postpartum care rates, an area identified as an opportunity for improvement across its counties. Both QIPs fell under the quality and access domains of care. Additionally, the *Postpartum Care* QIP fell under the timeliness domain of care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a PCP in an office or clinic setting. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

The *Postpartum Care* QIP aims to improve the rate of postpartum visits for women between 21 and 56 days after delivery. Ensuring that women are seen postpartum is important to the physical and mental health of the mother.

Quality Improvement Project Validation Findings

The table below summarizes the validation results for both QIPs across CMS protocol activities during the review period. HSAG validated QIPs at the county level beginning July 1, 2009, for new QIP projects and validated existing projects at the overall plan level; therefore, HSAG validated one QIP submission for the *Reducing Avoidable Emergency Room Visits* QIP and nine county-level QIP submissions for the *Postpartum Care* QIP.

Table 4.1—Quality Improvement Project Validation Activity for Anthem—Alameda, Contra Costa, Fresno, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare Counties July 1, 2010, through June 30, 2011

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					
Reducing Avoidable Emergency Room Visits (Combined Rate for All Plan Counties)	Overall	Annual Submission	85%	100%	*Met*
Internal QIPs					
Improving HEDIS Postpartum Care Rates	All Counties^	Annual Submission	83%	85%	*Not Met*
		Resubmission	100%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the plan 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*.

^All counties received the same validation score for their QIPs.

Validation results during the review period of July 1, 2010, through June 30, 2011, showed that the initial submission by Anthem of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Met*. Anthem received a *Partially Met* validation status for its *Postpartum Care* QIP submission for each county. Anthem lacked codes to identify postpartum care visits and codes to identify live births. As of July 1, 2009, the DHCS began requiring plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, Anthem resubmitted the *Postpartum Care* QIPs and upon subsequent validation, achieved an overall *Met* validation status for each county's QIP.

Table 4.2 summarizes the validation results for Anthem's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Anthem—Alameda, Contra Costa, Fresno, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare Counties (Number = 10 QIP Submissions, 2 QIP Topics) July 1, 2010, through June 30, 2011

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%
Design Total*		**100%**	**0%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	98%	2%	0%
	VI: Accurate/Complete Data Collection	99%	1%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total*		**99%**	**1%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	0%	0%	100%
Outcomes Total*		**93%**	**0%**	**7%**

*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.

HSAG validated QIPs at the county level beginning July 1, 2009, for new QIP projects and validated existing projects at the overall plan level; therefore, HSAG validated one QIP submission for the *Reducing Avoidable Emergency Room Visits* QIP and nine county-level QIP submissions for the *Postpartum Care* QIP. The county-level QIP submissions scores were the same for all nine counties.

Anthem submitted Remeasurement 2 data for the *Reducing Avoidable Emergency Room Visits* QIP; therefore, HSAG validated Activity I through Activity X. Only baseline data were submitted for the *Postpartum Care* QIPs, so Activity IX and Activity X could not be assessed.

Anthem demonstrated an excellent understanding of the design and implementation stages, scoring 100 percent on all applicable evaluation elements for five of the eight activities. Conversely, for the outcomes stage, Anthem was scored lower in Activity IX for the plan's inability to demonstrate improvement from Remeasurement 1 to Remeasurement 2 for its *Reducing Avoidable Emergency Room Visits* QIP and in Activity X for not achieving sustained improvement. Sustained improvement is defined as improvement in performance over baseline that is

maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes

Table 4.3 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3—Quality Improvement Project Outcomes for Anthem—Alameda, Contra Costa, Fresno, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare Counties July 1, 2010, through June 30, 2011

QIP #1—Reducing Avoidable Emergency Room Visits					
QIP Study Indicator	**County†**	**Baseline Period (1/1/07–12/31/07)**	**Remeasurement 1 (1/1/08–12/31/08)**	**Remeasurement 2 (1/1/09–12/31/09)**	**Sustained Improvement¥**
Percentage of avoidable ER visits	**Overall**	**18.6%**	**17.7%***	**19.2%***	**No**
	Alameda	18.7%	16.3%*	21.0%*	No
	Contra Costa	20.9%	17.7%*	19.5%*	Yes
	Fresno	16.4%	16.6%	18.0%*	No
	Sacramento	17.0%	15.7%*	18.0%*	No
	San Francisco	16.4%	16.3%	18.5%*	No
	San Joaquin	18.5%	18.3%	20.1%*	No
	Santa Clara	17.6%	17.7%	22.4%*	No
	Stanislaus	22.2%	21.1%*	18.4%*	Yes
	Tulare	21.3%	19.8%*	20.5%*	Yes

Table 4.3—Quality Improvement Project Outcomes for Anthem—Alameda, Contra Costa, Fresno, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare Counties July 1, 2010, through June 30, 2011

QIP #2—Improving HEDIS Postpartum Care Rates					
QIP Study Indicator	**County^**	**Baseline Period (1/1/09–12/31/09)**	**Remeasurement 1 (1/1/10–12/31/10)**	**Remeasurement 2 (1/1/11–12/31/11)**	**Sustained Improvement¥**
Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	**Overall**	**50.5%**	‡	‡	‡
	Alameda	43.3%	‡	‡	‡
	Contra Costa	28.8%	‡	‡	‡
	Fresno	55.7%	‡	‡	‡
	Sacramento	52.1%	‡	‡	‡
	San Francisco	57.4%	‡	‡	‡
	San Joaquin	48.9%	‡	‡	‡
	Santa Clara	55.5%	‡	‡	‡
	Stanislaus	54.26%	‡	‡	‡
	Tulare	46.47%	‡	‡	‡

† The county-specific rates are provided for informational purposes since only the overall rate was included in the validation.
^ The overall rate is provided for informational purposes since only the county-specific rates were included in the validation.
¥ Sustained improvement is defined as improvement in performance over baseline which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.
* 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 could not be assessed.

Anthem reported a decline in performance for *the Reducing Avoidable Emergency Room Visits* QIP outcome. The increase in the avoidable ER visits indicator outcome was statistically significant. Collaborative interventions were initiated in early 2009; however, they did not correspond to any improvement from Remeasurement 1 to Remeasurement 2. The plan did not achieve sustained improvement since it was unable to maintain the improvement reported between baseline and Remeasurement 1. Only Stanislaus County demonstrated improvement from Remeasurement 1 to Remeasurement 2. Contra Costa, Stanislaus, and Tulare counties achieved sustained improvement from baseline to Remeasurement 2.

Anthem had not progressed to the point of reporting remeasurement data for the county-level Postpartum Care QIPs, so real and sustained improvement could not be assessed.

Strengths

Anthem demonstrated an excellent understanding of the design and implementation stages and received *Met* scores for all evaluation elements in five of the eight activities.

Opportunities for Improvement

Anthem has an opportunity to improve its intervention strategies to order to achieve sustained improvement of its QIP outcomes. At a minimum, barrier analysis should be performed to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from an annual analysis alone. The plan should ensure that the barrier analysis for the *Postpartum Care* QIP is county-specific and that interventions are targeted to the county-specific barriers.

The plan implemented the collaborative interventions in 2009 for the *Reducing Avoidable ER Visits* QIP; however, when the plan implements multiple interventions, it should incorporate a method to evaluate the effectiveness of each intervention.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for Medi-Cal managed care members through the provision of health care services and the plan's structural and operational characteristics.

The DHCS uses the results of performance measures and quality improvement project (QIP) to assess care delivered to members by a plan 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, the DHCS monitors aspects of a plan'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.

The plan demonstrated below-average performance for the quality domain of care based on 2011 performance measure rates, QIP outcomes, and the results of the medical performance review standards related to measurement and improvement. As noted in Anthem's 2009–10 evaluation report,[7] the plan remains noncompliant in four areas identified in the medical performance review; and one of those areas is in the quality domain (the provision of adequate review of member grievances involving potential quality-of-care issues).

All of Anthem's counties except Santa Clara performed below the MPLs for at least one quality performance measure. Based on 2010 rates, Alameda, Contra Costa, and Sacramento counties had the greatest opportunity for improvement related to quality of care based on the number of measures falling below the MPLs (10, 12, and 11, respectively). Based on 2011 rates, Alameda and Contra Costa counties continue to have the greatest opportunity for improvement related to quality of care based on the number of measures falling below the MPLs (11 and 13, respectively). Sacramento showed some improvement in its overall performance in that it went from having 13 measures with below-average performance to eight.

[7] *Performance Evaluation Report – Anthem Blue Cross, July 1, 2009 – June 30, 2010.* California Department of Health Care Services. September 2011. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

All of Anthem's counties exceeded the MPLs for *Use of Imaging Studies for Low Back Pain, Appropriate Treatment for Children With Upper Respiratory Infection, BMI Assessment, Nutrition Counseling, and Physical Activity Counseling*. The top-performing county was Santa Clara, which had five rates above the HPLs and zero rates below the MPLs. San Francisco County had five rates above the HPLs and only one rate below the MPLs.

Anthem continues to struggle with its performance related to the quality domain. HSAG anticipates that implementation of the CAP required by the DHCS will result in significant improvements in Anthem's performance across the quality domain. If minimal improvements are made, it is recommended that the DHCS implement formal, progressive penalties until performance is meeting minimum requirements.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan'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 under the Medi-Cal Managed Care Program.

Performance measures, QIP outcomes, and member satisfaction results are used 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 members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

Anthem demonstrated below-average performance for the access domain of care based on 2011 performance measure rates, QIP outcomes, and results of the medical performance review standards related to the availability of and access to care. As noted in the 2009–10 evaluation report, three of the four outstanding areas of deficiency from the medical performance review are in the access domain, and there is no evidence from review of the plan's internal *2010 Quality Improvement Work Plan* that it is implementing strategies to address the deficiencies. Also noted was that the most recent MRPIU review indicated that Anthem's policies did not include information for addressing cultural and linguistic requirements for processing grievances.

Alameda and Contra Costa have the greatest opportunity for improvement related to the access domain based on the number of access measures falling below the MPLs (9 and 10, respectively). Santa Clara and San Francisco were the top performing counties related to the access domain with zero and one measure falling below the MPLs, respectively.

Although the plan demonstrated statistically significant decline in its overall plan rate between the baseline and first remeasurement periods for its *Reducing Avoidable Emergency Visits* QIP, it also reported a decline in performance from Remeasurement 1 to Remeasurement 2. This resulted in the plan being unable to achieve sustained improvement for this QIP. Remeasurement data were not available for the Postpartum Care QIP.

Overall, Anthem has many opportunities for improvement in the access domain. As with the quality domain, HSAG anticipates that implementation of the CAP will result in significant improvements in the plan's performance across the access domain.

Timeliness

The timeliness domain of care relates to a plan'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.

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' 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.

Anthem had below-average performance in the timeliness domain of care based on its 2011 performance measure rates for providing timely care.

All of Anthem's counties except Santa Clara performed below the MPLs for at least one of the five timeliness performance measures. No counties performed above the HPLs for any of the timeliness measures. Four counties (Alameda, Contra Costa, Fresno, and Sacramento) fell below the MPLs on four of the five measures.

The plan did demonstrate strength as noted in the prior year's evaluation report, during the most recent audit in 2009, for compliance with standards related to the timeliness of utilization management decisions, including prior-authorization requirements. The plan was also fully compliant with resolving member grievances within the appropriate time frame.

As with the quality and access measures, there is much room for improvement on the plan's performance on the timeliness measures.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2009–2010 plan-specific evaluation report. Anthem's self-reported responses are included in Appendix A.

Conclusions and Recommendations

In the next annual review, HSAG will evaluate Anthem's progress with these recommendations along with its continued successes.

Overall, Anthem demonstrated below-average performance in providing quality, timely, and accessible health care services to its MCMC members. Despite the development and implementation of several improvement plans, Anthem struggles with performing above the minimum standards. HSAG anticipates that implementation of the DHCS-required CAP will result in improvement in Anthem's performance across all domains of care.

Based on the overall assessment of Anthem in the areas of quality and timeliness of, and access to, care, HSAG recommends the following:

- Continue to incorporate medical performance review deficiencies in the internal quality improvement work plan to ensure that they are addressed and monitored.
- Continue to work closely with the DHCS on implementation and monitoring of the CAP.
- Continue efforts to improve the completeness of encounter data submissions and implement a process to monitor monthly provider volume to identify missing data sources.
- Explore the use of PM-160 data as a supplemental data source that may help to improve performance measure rates.
- Dedicate plan resources specific to the Medi-Cal managed care contract to increase the likelihood of success in improving performance.
- Create documentation of its HEDIS data workflow specific to the Medi-Cal managed care line of business to identify staff members for key stakeholders responsible for the various aspects of HEDIS reporting
- Conduct an objective evaluation of the effectiveness of interventions and improvement plans for HEDIS measures in which performance declined so improvements/modifications can be made and also for measures in which performance improved so successful interventions can be duplicated and/or continued.
- Perform barrier analysis to identify and prioritize barriers for each QIP measurement period.
- Ensure that the barrier analysis for the *Postpartum Care* QIP is county-specific, and interventions are targeted to the county-specific barriers.
- When implementing multiple interventions, incorporate a method to evaluate the effectiveness of each one.

Appendix A. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

for **Anthem Blue Cross Partnership Plan**

The table (grid) on the following page provides EQR recommendations from the July 1, 2009, through June 30, 2010 Performance Evaluation Report, along with Anthem's self-reported actions that address the recommendations. Neither Health Services Advisory Group, Inc. (the external quality review organization for Medi-Cal Managed Care) nor any State agency has confirmed implementation of the actions that the plan self-reported in the grid.

Table A.1—Grid of Anthem's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	Anthem's Self-Reported Actions That Address the EQR Recommendation
1. Incorporate medical performance review deficiencies in the quality improvement work plan to ensure that they are addressed and monitored.	We have incorporated this process into our Quality workplan and routinely monitor regulatory deficiencies through corrective action plans as scheduled within our Quality work plan and presented to the Quality Committee.
2. Monitor encounter data submission patterns from the vision vendor to improve data completeness.	There was an initiative with VSP to modify our contract with them to cover annual eye exams for diabetic members. VSP communicated the change to providers. We gave VSP a list of our diabetic members, and VSP sent a member letter in September 2011. A new process focusing on improving the DRE rate has been added for SSB this 2012 HEDIS season. The vision vendor will perform an additional claims sweep of all identified noncompliant members in our DRE sample. If visits are identified in the present year and/or year prior, the vision vendor will pursue the medical record and securely send the medical records to Anthem for abstraction. We are hopeful this will have a positive impact on our DRE rate for 2012. In addition, we review our ongoing vendor encounter submission patterns and volumes monthly to ensure consistent and an expected volume of encounters are transmitted each month.
3. Create a HEDIS team, dedicated to the Medi-Cal managed care product line, with responsibility to ensure coordination of activities and adherence to timelines.	In 2009, the State-sponsored Business Quality Management area was realigned under one Anthem Blue Cross management team to improve efficiency and outcomes. This business realignment provided an opportunity to leverage best practices and processes within the company. Over the past two years, all operational processes surrounding HEDIS have been evaluated. The staffing model was enhanced, and systemwide education and training for the medical record pursuit and abstraction process was implemented. Also, the IRR process has been standardized companywide. The SSB staff members have been included in enterprise work groups and/or regular meetings assisting with identifying best practices and resolving outstanding issues. Also in 2009, the HEDIS data collection and reporting team has been integrated into one department. This consolidation strategy aligns similar functions across the enterprise and centralizes technology and subject matter expertise into one area. Improvements and enhancements to data systems, collection methodology, and program oversight are now consolidated under the Enterprise HEDIS Quality Team.

Table A.1—Grid of Anthem's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

2009–2010 EQR Recommendation	Anthem's Self-Reported Actions That Address the EQR Recommendation
	In 2011 we employed a consultant to evaluate the HEDIS hybrid process that was being used in CA and to identify recommendations. Many of those recommendations are being implemented as part of the 2012 HEDIS process. Throughout the HEDIS data collection cycle, current status, progress/challenges and updates regarding medical record collection and abstraction are shared both with the teams that are accountable for results, as well as with their leaders weekly. This allows for immediate course correction and appropriate resourcing. Greater efficiency has been attained by pushing this information to the teams that need it, as well as by the close monitoring of real time results during the HEDIS data collection process. A review of the HEDIS data collection process identified significant barriers. The implementation of a policy to use qualified non-RN temporary staffing to collect and abstract HEDIS chart data resulted in an increase from 16 to 24 temporary staff for the 2008, 2009, and 2010 data collection cycles and to 46 temporary staff for the 2011 cycle.
4. Establish performance standards with the HEDIS software vendor to reduce delays.	Anthem works collaboratively with Verisk Health, our NCQA-Certified HEDIS software vendor. Verisk supports Anthem in the production of HEDIS results; and in 2011, Verisk appointed dedicated staff that attended the internal HEDIS staff daily production meetings listening to outstanding issues and assisting with resolutions. This collaboration has resulted in more efficient production processes. Anthem staff members have also attended and benefitted from on-site and off-site Verisk training. Also in 2012, support from Verisk continues and will continue in the daily production meetings; and the HEDIS staff members continue attending online training to enhance knowledge and skill level of using the Verisk software. Annually, just following the HEDIS season, all identified problems are collected from all business units and cataloged. In 2011 the top 10 critical issues were identified specific to line of business and worked thru resolution, reporting the status throughout all levels of leadership. Once our data is loaded into our HEDIS software (Verisk Sightlines), additional validation occurs to ensure that the data were processed cleanly. If more than 5 percent of the records did not process cleanly, additional evaluation occurs to determine an appropriate course of action before approving the data for measures to be run. Once initial measure results are obtained, measures meeting criteria are submitted to HEDIS auditors for benchmarking. Measures that do not meet criteria are evaluated to identify the reason for the variance to the criteria or norm.

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5. Explore factors that contributed to the significant drop in *Comprehensive Diabetes Care—Retinal Eye Exam* rates.	One key factor identified that contributed to the decrease in retinal eye exams for diabetic members was the change in the eye exam benefit midyear. Chart reviewers noticed a greater increase in member noncompliance with diabetic regime, including lab test and diabetic medications as documented by the physician. Also, the reviewers observed physician noncompliance with ordering appropriate tests for diabetic members which would have impacted HbA1c. The DHCS announced its elimination of optional adult optometry services in 2009 but then restored the benefit. Many beneficiaries and some providers continue to believe that there are no optometry benefits and DREs. We worked with VSP to change the contract to cover annual eye exams for diabetic members, and VSP communicated this change to providers; and a member mailing occurred in September 2011. Also see response in Item #2 above.
6. Identify factors that contributed to the decline in performance measure rates for Fresno County.	There was a decline in rates for Breast Cancer Screening (BCS), Diabetic Retinal Eye Exam (DRE) and Postpartum Care (PPC-Post) in RY 2010. In 2010, new HEDIS software was implemented. The HEDIS team has actively analyzed and created an intervention plan for any identified issues with the new software. Ultimately we believe this should enhance better data capture. We met with the eye vendor VSP to modify the contract to cover eye exams. This is outlined in the above responses to Items #2 and #5.
7. Increase quality improvement resources for Alameda, Contra Costa, and Sacramento counties until the plan's performance achieves the MCMC-established MPLs.	In 2009 and 2010, the State--sponsored Business CRC field operations teams have struggled to maintain critical provider relationships with providers in Contra Costa County. Our field staff depends heavily on good provider relationships in order to maintain easy access to member information as well as the ability to better coordinate services when needed. It is this access that improves the flow of HEDIS-related information, and challenged relationships have had a negative impact on our ability to effectively work on HEDIS improvement. Contra Costa County has been a particularly challenging market given State-sponsored Business' status as a competing health plan to the Contra Costa County Health Plan and the county clinics which were used by the majority of providers serving Medi-Cal. These competing relationships have been a challenge to maintaining an adequate network as they rely on the support of two Alameda County-based PMGs and a limited fee-for-service network. At the end of 2010, Anthem Blue Cross staff started an effort to reach out to Contra Costa County providers to better understand how we could work closer with these providers and partner to improve the overall quality of care delivered to members. Focusing on HEDIS-related measures, dialogue began with certain capitated county providers (including those in Alameda, Contra Costa, and Sacramento) and continues to expand to existing fee-for-service providers. According to these local providers, the primary challenge to this partnership is unclear and poorly-delineated communication channels. In

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	response, a new Contra Costa County provider outreach effort was launched to reintroduce Anthem Blue Cross to the providers in the county. Additionally, contact was made with the local medical societies to strengthen relationships and gain support in connecting their membership with the appropriate CRC field staff for support and issue resolution. The process of facilitating and encouraging the provider and provider organizations to provide clean and accurate data is planned to be an integrated approach between provider data management, provider encounter data, HEDIS clinical data, provider contracting, and field operations teams. The field operations teams are using data from SSB-related provider data management, HEDIS clinical data management, and encounter data to engage PMG provider organizations as well as individual providers in a direct member-by-member and service-by-service intervention. Field operations teams are working on an ongoing basis with provider data management to improve and update the existing provider data. It is critical that all contract physician-basic information—their applicable product lines, physical address, telephone number, e=mail and fax information—is loaded and correct. Often, this had not been the case, which causes numerous problems that can affect HEDIS-related data accuracy. We have developed a routine Gaps-in-Care Reporting process which was initiated in June 2011. These reports are at the PMG Level and are generated monthly (April through November) using the Verisk Sightlines Tool. Our Community Resource Coordinators (CRCs) field staff have direct access to run reports, communicate monthly results and work with providers as necessary to improve levels. Please also see key quality/HEDIS staffing changes discussed above in Item #3.
8. Revise performance measure improvement plans using evidenced-based and/or best practices to increase the likelihood of success for measures that are not showing improvement.	Going forward we will include evidence-based literature and best practices into the intervention planning that is reflected in the performance measure improvement plans.

Table A.1—Grid of Anthem's Follow-Up on EQR Recommendations From the July 1, 2009–June 30, 2010 Performance Evaluation Report

<table>
<tr><th>2009–2010
EQR Recommendation</th><th>Anthem's Self-Reported Actions That Address the EQR Recommendation</th></tr>
<tr><td>9. Review the 2010 plan-specific CAHPS results report and develop strategies to address the Getting Needed Care, Customer Service, and Rating of All Health Care priority areas.</td><td>
See attached barrier analysis and strategic plan for CAHPS results.

Response to DHCS Request for QI Initiatives Implemented
To Improve Designated CA Medicaid CAHPS Scores

Rating of Overall Satisfaction With All Health Care in Past 12 Months
<table>
<tr><th>Barrier</th><th>Action Plan / Intervention</th></tr>
<tr><td>Network doctors not aware of how their services are perceived by their patients.</td><td>Annually share with network practitioners CAHPS scores related to provider services in Provider Newsletter. Encourage doctors to assess their own practices in the areas, making any needed adjustment to the services they provide.</td></tr>
<tr><td>Doctors have no tools that outline how to make their patient's experience a positive one.</td><td>Brochure "Guide to Improving the Patient Experience" added to provider website. Brochure is a resource to educate network doctors about how to effectively interact with patients to ensure a positive outcome in terms of patient satisfaction and improved care.</td></tr>
</table>

Rating of Satisfaction With Getting Needed Care - Composite
How often easy to get appt. with specialist?
How often easy to get care, tests, or treatment you needed via health plan?
(% responding usually or always)
<table>
<tr><th>Barrier</th><th>Action Plan / Intervention</th></tr>
<tr><td>UM processes are not as efficient as needed.</td><td>Several UM Re-engineering initiatives have taken place to simplify work processes and transition functions to non-clinical staff, where appropriate. Ultimate goals are to improve customer satisfaction through quicker decision-making and lower overall administrative costs of reviews.
Some examples:
– Revised Auth. Indicator and Network tools to enable more authorization approvals at time of Intake.
– Increased use of Non-clinical staff to assist with decision notifications.</td></tr>
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2009–2010 EQR Recommendation	Anthem's Self-Reported Actions That Address the EQR Recommendation	
		Initiated the use of the full spectrum of Milliman guidelines to increase the number of cases that could be managed by a nurse vs. Medical Director.
	UM processes are not as efficient as needed.	Increased integration between Case Management and Concurrent Stay Review with the Discharge Planning process.
		Rightfax filenet was implemented early in April 2010 and is fully functioning. Rightfax Filenet simplifies the process of when a fax is received within UM. The fax is received electronically, rather than in paper form. A specific document control number (DCN) is assigned to the fax, which will link the fax information to a WMDS case.
		In March 2010, a new Peer-to-Peer Reconsideration workflow was implemented which allows the PCR (Physician Clinical Reviewer) permission to overturn an adverse determination within 30 days of a denial, when new clinical information is received. Appeals would be required after the 30 day window.
		In September 2010 the newly reduced Prior Authorization list was implemented which will increase Provider satisfaction with PA process. This list is in sync with that of our other business lines and will provide consistency for our providers and ease the authorization process.
	Rating of Satisfaction With Customer Service - Composite ***How often received needed information or help from customer service?*** ***How often did customer service staff treat you with courtesy & respect?*** ***(% responding usually or always)***	
	Barrier	**Action Plan / Intervention**
	Customer Service Representatives not providing the best service possible	Continued implementation of the Customer Advocacy model builds trust with members by meeting expectations and giving representatives empowerment to break down barriers to providing good service. • A multi-phase approach focused on accuracy, service skills training, and identifying advocacy opportunities. • All managers, representatives and coaches all have shared goals focused on "customer satisfaction"

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		The Customer Advocacy model enables representatives to be responsible for: • taking ownership of the members' problems; • being proactive; • consultatitive recommendations; and • problem-solving;
	Need closer monitoring and feedback mechanisms to improve Customer Service Representatives' (CSR) service skills.	• Soft skills training was rolled out to all advocates. • Continued focus on key service skills, acknowledge and confirm, take the member out of the middle, deliver on promises. • Partnering with call coaching on feedback sessions with CSAs and managers • Engaging other operations areas in understanding impacts to customer satisfaction and areas of opportunity to help drive satisfaction increases. • Continue to include member satisfaction performance as a key component in QIP and annual performance for all Service Ops associates. • Implemented Enhanced Call Closing in Q4 2009 which contributed to increases in First Call Resolution. (FCR) • Developing FCR reporting tools for drill-down on member satisfaction. • A new process is in place that allows the CSA to email our members. This promotes quicker turnaround time and increases member satisfaction. • The team created a monthly Member Satisfaction Root Cause report that can directly tie action items to Member Satisfaction data. • Implemented new policy designed to improve FCR and member satisfaction that allows advocates to call Enrollment & Benefits directly to answer member questions.
		Each associate is provided feedback from member survey; whether it is an opportunity for improvement or to recognize efforts for a job well done.

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2009–2010 EQR Recommendation	Anthem's Self-Reported Actions That Address the EQR Recommendation

Rating of Satisfaction With Customer Service - Composite
(continued)

Barrier	Action Plan / Intervention
Customer Service staff don't have adequate information resources to properly service our members.	Implement an Enterprise-wide Knowledge Library which will standardize document formats and create a single source of truth for operational documentation. Benefits to include the following: * Decreased average call handle time - allows for easier access of information by assoc. * Increased member satisfaction- single call resolution * Defined consistent enterprise processes * Ensured accurate, up-to-date content * Use of common language and standard document type
Customer Service staff need a way to handle issues requiring immediate resolution.	Implemented an escalation process to address issues requiring immediate attention.