Performance Evaluation Report

Anthem Blue Cross Partnership Plan

July 1, 2011–June 30, 2012

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

June 2013

TABLE OF CONTENTS

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Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] 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 designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more 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.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, 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.

This report is specific to DHCS's contracted plan, Anthem Blue Cross Partnership Plan ("Anthem" or "the plan"), which delivers care in Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare counties, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

Plan Overview

Anthem, formerly Blue Cross of California prior to April 1, 2008, is a full-scope Medi-Cal managed care plan operating in 11 counties during the reporting period. Anthem delivers care to members using the Two-Plan model for all counties except Sacramento, in which care is delivered using the Geographic Managed Care (GMC) model.

In a Two-Plan model county, 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 an LI in Stanislaus and Tulare counties and delivers care as a nongovernmental commercial plan in Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, San Joaquin, and Santa Clara counties.

In the GMC model, DHCS contracts with several commercial health plans within a specified geographic area—in this case, Sacramento County. This provides Medi-Cal managed care beneficiaries with more choices.

Anthem initiated services under the Medi-Cal program in Sacramento County in 1994, with expansion into additional counties occurring in subsequent years: Alameda, Contra Costa, Fresno, San Francisco, and Santa Clara in 1996; San Joaquin in 1997; Stanislaus in 2004; and Tulare in 2005. The most recent expansion was in March 2011 with the addition of Kings and Madera counties and the continuation of Fresno County under a new contract covering Fresno, Kings, and Madera counties. As of June 30, 2012, Anthem had 450,642 enrolled members under the Medi-Cal program for all of its contracted counties combined.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period 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.

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 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 Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from 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. DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of DHCS's Medi-Cal Managed Care Division (MMCD) have historically worked in conjunction with the Department of Managed Health Care to conduct joint audits of Medi-Cal managed care plans. In some instances, however, medical performance audits have been conducted solely by DHCS or the Department of Managed Health Care. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each Medi-Cal managed care plan approximately once every three years.

In September of 2009, DHCS conducted a medical performance review, 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.[4] 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, but several deficiencies were noted as well.

Although Anthem resolved several of the identified deficiencies, the plan had not fully resolved deficiencies at the time of DHCS's September 14, 2010, final audit close-out letter in the areas of monitoring appointment wait times, time and distance standards for primary care providers (PCPs) 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. HSAG reviewed internal quality improvement documentation provided by Anthem to determine the progress Anthem has made toward addressing the 2009 deficiencies:

- The plan provided documentation that indicates Anthem has included corrective action plan (CAP) monitoring activities to ensure that actions are taken to address areas of deficiency and opportunities for improvement are documented, tracked, and monitored for compliance.
- The plan's 2011 Quality Improvement Program Evaluation report described ongoing challenges related to appointment wait times, and the 2012 Quality Improvement Workplan included a goal to analyze the performance of PCPs related to appointment access standards.
- Anthem's 2011 Quality Improvement Program Evaluation report indicated that Contra Costa did not meet the time and distance standards for PCPs. Anthem's 2012 Quality Improvement Workplan included a goal to monitor the time and distance standards for PCPs, which demonstrates that the plan is aware of the importance of ensuring members have access to PCPs.
- HSAG did not locate any information regarding the plan's oversight of hospitals to ensure access to medications in emergency situations.
- Anthem's 2012 Quality Improvement Workplan indicated that annually, the plan reviews member grievances for potential continuity and coordination of care issues and trends with practitioners or facilities.

While Anthem demonstrates some action toward resolving the noted deficiencies in DHCS's medical audit, it does not appear that all of them have been fully resolved based on the information submitted by the plan.

[4] *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.

Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current medical performance reviews and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

The most current MR/PIU 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,[5] which indicated that MR/PIU identified findings in member grievances, prior authorization notification, and cultural and linguistic services. Anthem was not required to respond to the findings. MR/PIU will follow up with the plan on the findings during its next review. Listed below are the findings:

Member Grievances

Finding

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

[5] *Performance Evaluation Report – Anthem Blue Cross, July 1, 2008 – June 30, 2009*. California Department of Health Care Services. December 2010. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx.

Prior Authorization Notification

Findings

- The policies and procedures submitted did not include the required record retention time frame.
- The plan's subcontractors were not fully compliant with ensuring that the notice of action (NOA) templates and "Your Rights" attachment were implemented in accordance with the requirements.
- The NOA letter in one out of two prior authorization files reviewed for a subcontracted entity, was missing the required reason or citation supporting the action taken.

Cultural and Linguistic Services

Findings

- 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.
- It was noted through field visits that at two provider offices, if a member called the office after hours, the telephone message was in English or Spanish only.
- It was noted through field visits to several providers' offices that they encourage members to use family/friends as interpreters.

Although Anthem's submitted quality documents include activities related to grievances, prior authorization notification, and cultural and linguistic services, HSAG's review of the documents did not reveal information regarding actions the plan has taken to address the findings from the MR/PIU review.

Strengths

Anthem demonstrated some progress in addressing deficiencies noted in the medical performance review. The plan's CAP monitoring activities, over time, should result in better identification of areas in need of improvement and strategies that will lead to Anthem being fully compliant with all requirements.

Opportunities for Improvement

The documents Anthem submitted as part of the plan-specific evaluation report process do not appear to include activities to specifically address all areas of outstanding deficiencies from the medical performance review or findings from the MR/PIU review. The deficient areas fall primarily in the access domain of care and should be an area of focus for the plan. While Anthem appears to have monitoring activities in place, it is important that the plan identify and document specific ways the plan is addressing the deficiencies in addition to the ongoing monitoring. The frequent and consistent monitoring of the plan allows the State to better determine the plan's progress with prior year deficiencies.

Conducting the Review

DHCS annually selects a set of performance measures—in consultation with contracted plans, the EQRO, and stakeholders—to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members. These DHCS-selected measures are referred to as the External Accountability Set (EAS). 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 DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by DHCS for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the plan's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

DHCS's 2012 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and an internally developed measure for the statewide collaborative QIP that fell under all three domains of care—quality, access, and timeliness. HSAG performed a HEDIS Compliance Audit™ of Anthem in 2012 to determine whether the plan followed the appropriate specifications to produce valid rates.

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

Performance Measure Validation Findings

HSAG's audit found all 2012 performance measures rates to be reportable. HSAG provided the following recommendations:

- Anthem should work to capture the rendering provider type on all service data and consider making contract changes to reflect the requirements moving forward.
- Anthem is encouraged to work with HSAG when developing additional supplemental sources of data to ensure the data sources meet NCQA reporting requirements.

Performance Measure Results

After validating the plan's performance measure rates, HSAG assessed the results. The following table displays a performance measure name key with abbreviations contained in Tables 3.2 through 3.9.

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions (internally developed measure)*
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
AWC	*Adolescent Well-Care Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Table 3.1—Performance Measures Name Key

Abbreviation	Full Name of 2012 Performance Measure
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Tables 3.2 through 3.9 present a summary of Anthem's HEDIS 2012 performance measure results (based on calendar year [CY] 2011 data) compared to HEDIS 2011 performance measure results (based on CY 2010 data). To create a uniform standard for assessing plans on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for first-year measures or measures that had significant specifications changes impacting comparability. The tables show the plan's HEDIS 2012 performance compared to the DHCS-established MPLs and HPLs. While the *All-Cause Readmissions* (ACR) measure was audited to ensure valid and reliable reporting, the reported rates and analysis for this measure will be reported in an interim report of the statewide collaborative in mid-2013.

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

Since Anthem began providing services in Kings and Madera counties beginning in March 2011, the plan was not required to report on measures for these counties during the review period. Anthem also was not required to report on measures for Fresno County because DHCS established a new contract with Anthem for Fresno County in March 2011. Therefore, the performance measure findings and recommendations do not include information on these three counties. The plan will be required to report performance measure rates for all three counties beginning in 2013.

Table 3.2—Comparison of 2011 and 2012 Performance Measure Results for Anthem Blue Cross Partnership Plan—Alameda County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	34.3%	39.1%	★★★	↔	18.8%	31.6%
AMB–ED	‡	--	55.6	--	Not Comparable	--	--
AMB–OP	‡	--	215.9	--	Not Comparable	--	--
AWC	Q,A,T	32.8%	39.4%	★	↑	39.6%	64.1%
CAP–1224	A	--	93.5%	--	Not Comparable	--	--
CAP–256	A	--	82.9%	--	Not Comparable	--	--
CAP–711	A	--	84.1%	--	Not Comparable	--	--
CAP–1219	A	--	79.4%	--	Not Comparable	--	--
CCS	Q,A	54.0%	58.2%	★	↔	64.0%	78.7%
CDC–BP	Q	50.6%	47.4%	★	↔	54.3%	76.0%
CDC–E	Q,A	28.0%	35.3%	★	↑	43.8%	70.6%
CDC–H8 (<8.0%)	Q	37.7%	32.4%	★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	53.5%	60.6%	★	↓	52.1%	29.1%
CDC–HT	Q,A	72.7%	73.5%	★	↔	77.6%	90.9%
CDC–LC (<100)	Q	29.2%	22.4%	★	↓	27.3%	45.9%
CDC–LS	Q,A	68.4%	66.9%	★	↔	70.4%	84.2%
CDC–N	Q,A	68.9%	68.9%	★	↔	73.9%	86.9%
CIS–3	Q,A,T	66.9%	70.6%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	65.0%	--	Not Comparable	--	--
LBP	Q	86.9%	91.5%	★★★	↔	72.3%	82.3%
MPM–ACE	Q	--	79.4%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	72.9%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	65.9%	73.0%	★	↑	80.3%	93.2%
PPC–Pst	Q,A,T	51.1%	50.6%	★	↔	59.6%	75.2%
W-34	Q,A,T	62.0%	73.7%	★★	↑	66.1%	82.9%
WCC–BMI	Q	47.0%	44.0%	★★	↔	19.7%	69.8%
WCC–N	Q	55.2%	62.0%	★★	↑	39.0%	72.0%
WCC–PA	Q	28.5%	31.1%	★★	↔	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

NA = A *Not Applicable* audit finding because the plan's denominator was too small.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Table 3.3—Comparison of 2011 and 2012 Performance Measure Results for Anthem Blue Cross Partnership Plan—Contra Costa County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	30.0%	NA	Not Comparable	Not Comparable	18.8%	31.6%
AMB–ED	‡	--	52.2	--	Not Comparable	--	--
AMB–OP	‡	--	213.8	--	Not Comparable	--	--
AWC	Q,A,T	26.8%	40.1%	★★	↑	39.6%	64.1%
CAP–1224	A	--	93.0%	--	Not Comparable	--	--
CAP–256	A	--	82.7%	--	Not Comparable	--	--
CAP–711	A	--	80.0%	--	Not Comparable	--	--
CAP–1219	A	--	80.3%	--	Not Comparable	--	--
CCS	Q,A	53.0%	58.2%	★	↔	64.0%	78.7%
CDC–BP	Q	55.2%	46.7%	★	↔	54.3%	76.0%
CDC–E	Q,A	26.4%	36.5%	★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	35.2%	29.2%	★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	58.4%	65.7%	★	↔	52.1%	29.1%
CDC–HT	Q,A	69.6%	67.2%	★	↔	77.6%	90.9%
CDC–LC (<100)	Q	26.4%	16.8%	★	↔	27.3%	45.9%
CDC–LS	Q,A	61.6%	57.7%	★	↔	70.4%	84.2%
CDC–N	Q,A	66.4%	65.0%	★	↔	73.9%	86.9%
CIS–3	Q,A,T	68.6%	68.4%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	65.0%	--	Not Comparable	--	--
LBP	Q	85.9%	92.6%	★★★	↔	72.3%	82.3%
MPM–ACE	Q	--	76.7%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	67.9%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	69.4%	76.3%	★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	43.5%	48.1%	★	↔	59.6%	75.2%
W-34	Q,A,T	63.3%	67.4%	★★	↔	66.1%	82.9%
WCC–BMI	Q	49.1%	42.6%	★★	↔	19.7%	69.8%
WCC–N	Q	52.8%	53.8%	★★	↔	39.0%	72.0%
WCC–PA	Q	35.3%	25.5%	★	↓	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

NA = A *Not Applicable* audit finding because the plan's denominator was too small.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Table 3.4—Comparison of 2011 and 2012 Performance Measure Results for Anthem Blue Cross Partnership Plan—Sacramento County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	23.1%	24.1%	★★	↔	18.8%	31.6%
AMB–ED	‡	--	41.3	--	Not Comparable	--	--
AMB–OP	‡	--	210.8	--	Not Comparable	--	--
AWC	Q,A,T	28.7%	51.3%	★★	↑	39.6%	64.1%
CAP–1224	A	--	94.5%	--	Not Comparable	--	--
CAP–256	A	--	81.9%	--	Not Comparable	--	--
CAP–711	A	--	81.2%	--	Not Comparable	--	--
CAP–1219	A	--	80.2%	--	Not Comparable	--	--
CCS	Q,A	61.8%	58.9%	★	↔	64.0%	78.7%
CDC–BP	Q	55.0%	56.2%	★★	↔	54.3%	76.0%
CDC–E	Q,A	28.2%	32.4%	★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	43.6%	49.1%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	47.9%	42.6%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	76.4%	76.2%	★	↔	77.6%	90.9%
CDC–LC (<100)	Q	29.7%	25.8%	★	↔	27.3%	45.9%
CDC–LS	Q,A	64.5%	62.0%	★	↔	70.4%	84.2%
CDC–N	Q,A	72.0%	71.5%	★	↔	73.9%	86.9%
CIS–3	Q,A,T	57.7%	57.4%	★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	51.6%	--	Not Comparable	--	--
LBP	Q	83.7%	84.9%	★★★	↔	72.3%	82.3%
MPM–ACE	Q	--	61.7%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	61.8%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	70.3%	76.9%	★	↑	80.3%	93.2%
PPC–Pst	Q,A,T	49.9%	54.3%	★	↔	59.6%	75.2%
W-34	Q,A,T	73.7%	64.3%	★	↓	66.1%	82.9%
WCC–BMI	Q	49.9%	63.0%	★★	↑	19.7%	69.8%
WCC–N	Q	59.6%	71.3%	★★	↑	39.0%	72.0%
WCC–PA	Q	27.7%	39.4%	★★	↑	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

NA = A *Not Applicable* audit finding because the plan's denominator was too small.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Table 3.5—Comparison of 2011 and 2012 Performance Measure Results for Anthem Blue Cross Partnership Plan—San Francisco County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	50.0%	50.5%	★★★	↔	18.8%	31.6%
AMB–ED	‡	--	38.8	--	Not Comparable	--	--
AMB–OP	‡	--	250.8	--	Not Comparable	--	--
AWC	Q,A,T	55.7%	63.3%	★★	↑	39.6%	64.1%
CAP–1224	A	--	95.4%	--	Not Comparable	--	--
CAP–256	A	--	90.8%	--	Not Comparable	--	--
CAP–711	A	--	91.7%	--	Not Comparable	--	--
CAP–1219	A	--	89.6%	--	Not Comparable	--	--
CCS	Q,A	74.5%	74.1%	★★	↔	64.0%	78.7%
CDC–BP	Q	75.4%	62.3%	★★	↓	54.3%	76.0%
CDC–E	Q,A	46.3%	51.6%	★★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	55.7%	53.5%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	32.5%	34.0%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	84.2%	83.7%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	36.0%	37.7%	★★	↔	27.3%	45.9%
CDC–LS	Q,A	75.4%	69.8%	★	↔	70.4%	84.2%
CDC–N	Q,A	81.8%	80.0%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	79.1%	72.4%	★★	↓	64.4%	82.6%
IMA–1	Q,A,T	--	69.4%	--	Not Comparable	--	--
LBP	Q	85.4%	80.4%	★★	↔	72.3%	82.3%
MPM–ACE	Q	--	80.1%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	79.1%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	88.0%	85.7%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	55.5%	64.0%	★★	↔	59.6%	75.2%
W-34	Q,A,T	76.4%	80.0%	★★	↔	66.1%	82.9%
WCC–BMI	Q	53.5%	73.2%	★★★	↑	19.7%	69.8%
WCC–N	Q	70.8%	79.3%	★★★	↑	39.0%	72.0%
WCC–PA	Q	56.2%	71.8%	★★★	↑	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

NA = A *Not Applicable* audit finding because the plan's denominator was too small.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Table 3.6—Comparison of 2011 and 2012 Performance Measure Results for Anthem Blue Cross Partnership Plan—San Joaquin County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	8.8%	11.6%	★	↔	18.8%	31.6%
AMB–ED	‡	--	39.8	--	Not Comparable	--	--
AMB–OP	‡	--	214.4	--	Not Comparable	--	--
AWC	Q,A,T	41.1%	51.1%	★★	↑	39.6%	64.1%
CAP–1224	A	--	90.7%	--	Not Comparable	--	--
CAP–256	A	--	74.0%	--	Not Comparable	--	--
CAP–711	A	--	80.0%	--	Not Comparable	--	--
CAP–1219	A	--	78.0%	--	Not Comparable	--	--
CCS	Q,A	61.6%	55.4%	★	↔	64.0%	78.7%
CDC–BP	Q	56.7%	61.6%	★★	↔	54.3%	76.0%
CDC–E	Q,A	37.7%	36.5%	★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	35.5%	43.1%	★★	↑	39.9%	59.1%
CDC–H9 (>9.0%)	Q	57.4%	50.1%	★★	↑	52.1%	29.1%
CDC–HT	Q,A	77.9%	73.5%	★	↔	77.6%	90.9%
CDC–LC (<100)	Q	28.7%	30.7%	★★	↔	27.3%	45.9%
CDC–LS	Q,A	72.5%	68.1%	★	↔	70.4%	84.2%
CDC–N	Q,A	76.9%	74.7%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	64.5%	67.9%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	59.4%	--	Not Comparable	--	--
LBP	Q	76.4%	78.1%	★★	↔	72.3%	82.3%
MPM–ACE	Q	--	80.1%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	79.1%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	79.3%	78.6%	★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	51.3%	48.2%	★	↔	59.6%	75.2%
W-34	Q,A,T	74.9%	73.8%	★★	↔	66.1%	82.9%
WCC–BMI	Q	49.9%	63.5%	★★	↑	19.7%	69.8%
WCC–N	Q	70.6%	81.5%	★★★	↑	39.0%	72.0%
WCC–PA	Q	28.7%	60.3%	★★	↑	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

NA = A *Not Applicable* audit finding because the plan's denominator was too small.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Table 3.7—Comparison of 2011 and 2012 Performance Measure Results for Anthem Blue Cross Partnership Plan—Santa Clara County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	28.8%	20.0%	★★	↓	18.8%	31.6%
AMB–ED	‡	--	37.9	--	Not Comparable	--	--
AMB–OP	‡	--	232.4	--	Not Comparable	--	--
AWC	Q,A,T	44.3%	52.8%	★★	↑	39.6%	64.1%
CAP–1224	A	--	95.6%	--	Not Comparable	--	--
CAP–256	A	--	86.7%	--	Not Comparable	--	--
CAP–711	A	--	87.6%	--	Not Comparable	--	--
CAP–1219	A	--	86.3%	--	Not Comparable	--	--
CCS	Q,A	72.0%	72.2%	★★	↔	64.0%	78.7%
CDC–BP	Q	72.5%	65.7%	★★	↓	54.3%	76.0%
CDC–E	Q,A	53.8%	64.5%	★★	↑	43.8%	70.6%
CDC–H8 (<8.0%)	Q	60.1%	61.3%	★★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	31.9%	29.4%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	87.3%	85.9%	★★	↔	77.6%	90.9%
CDC–LC (<100)	Q	46.7%	47.2%	★★★	↔	27.3%	45.9%
CDC–LS	Q,A	84.7%	82.7%	★★	↔	70.4%	84.2%
CDC–N	Q,A	83.0%	79.6%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	70.6%	66.9%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	60.1%	--	Not Comparable	--	--
LBP	Q	83.9%	82.4%	★★★	↔	72.3%	82.3%
MPM–ACE	Q	--	85.0%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	84.2%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	83.5%	79.5%	★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	65.7%	60.6%	★★	↔	59.6%	75.2%
W-34	Q,A,T	70.1%	76.7%	★★	↑	66.1%	82.9%
WCC–BMI	Q	65.7%	53.3%	★★	↓	19.7%	69.8%
WCC–N	Q	63.5%	70.6%	★★	↑	39.0%	72.0%
WCC–PA	Q	35.5%	38.4%	★★	↔	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

NA = A *Not Applicable* audit finding because the plan's denominator was too small.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Table 3.8—Comparison of 2011 and 2012 Performance Measure Results for Anthem Blue Cross Partnership Plan—Stanislaus County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	24.9%	25.0%	★★	↔	18.8%	31.6%
AMB–ED	‡	--	55.8	--	Not Comparable	--	--
AMB–OP	‡	--	311.2	--	Not Comparable	--	--
AWC	Q,A,T	29.9%	45.5%	★★	↑	39.6%	64.1%
CAP–1224	A	--	96.0%	--	Not Comparable	--	--
CAP–256	A	--	89.2%	--	Not Comparable	--	--
CAP–711	A	--	88.5%	--	Not Comparable	--	--
CAP–1219	A	--	85.8%	--	Not Comparable	--	--
CCS	Q,A	67.2%	61.2%	★	↔	64.0%	78.7%
CDC–BP	Q	57.7%	65.2%	★★	↑	54.3%	76.0%
CDC–E	Q,A	22.4%	40.6%	★	↑	43.8%	70.6%
CDC–H8 (<8.0%)	Q	34.1%	49.6%	★★	↑	39.9%	59.1%
CDC–H9 (>9.0%)	Q	58.4%	44.0%	★★	↑	52.1%	29.1%
CDC–HT	Q,A	76.2%	76.2%	★	↔	77.6%	90.9%
CDC–LC (<100)	Q	24.8%	32.1%	★★	↑	27.3%	45.9%
CDC–LS	Q,A	72.3%	70.6%	★★	↔	70.4%	84.2%
CDC–N	Q,A	71.3%	72.7%	★	↔	73.9%	86.9%
CIS–3	Q,A,T	58.9%	65.7%	★★	↑	64.4%	82.6%
IMA–1	Q,A,T	--	54.3%	--	Not Comparable	--	--
LBP	Q	79.5%	80.5%	★★	↔	72.3%	82.3%
MPM–ACE	Q	--	83.0%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	83.2%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	84.6%	88.6%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	53.7%	56.7%	★	↔	59.6%	75.2%
W-34	Q,A,T	69.3%	64.4%	★	↔	66.1%	82.9%
WCC–BMI	Q	33.1%	49.6%	★★	↑	19.7%	69.8%
WCC–N	Q	45.0%	63.0%	★★	↑	39.0%	72.0%
WCC–PA	Q	23.1%	37.2%	★★	↑	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

NA = A *Not Applicable* audit finding because the plan's denominator was too small.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Table 3.9—Comparison of 2011 and 2012 Performance Measure Results for Anthem Blue Cross Partnership Plan—Tulare County

Performance Measure[1]	Domain of Care[2]	2011 HEDIS Rates[3]	2012 HEDIS Rates[4]	Performance Level for 2012	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	15.8%	20.2%	★★	↑	18.8%	31.6%
AMB–ED	‡	--	25.6	--	Not Comparable	--	--
AMB–OP	‡	--	195.0	--	Not Comparable	--	--
AWC	Q,A,T	35.8%	48.7%	★★	↑	39.6%	64.1%
CAP–1224	A	--	92.5%	--	Not Comparable	--	--
CAP–256	A	--	71.0%	--	Not Comparable	--	--
CAP–711	A	--	81.8%	--	Not Comparable	--	--
CAP–1219	A	--	82.2%	--	Not Comparable	--	--
CCS	Q,A	67.2%	68.9%	★★	↔	64.0%	78.7%
CDC–BP	Q	65.0%	68.1%	★★	↔	54.3%	76.0%
CDC–E	Q,A	29.2%	33.1%	★	↔	43.8%	70.6%
CDC–H8 (<8.0%)	Q	42.1%	45.3%	★★	↔	39.9%	59.1%
CDC–H9 (>9.0%)	Q	49.6%	45.7%	★★	↔	52.1%	29.1%
CDC–HT	Q,A	77.1%	77.1%	★	↔	77.6%	90.9%
CDC–LC (<100)	Q	31.9%	33.1%	★★	↔	27.3%	45.9%
CDC–LS	Q,A	69.8%	68.6%	★	↔	70.4%	84.2%
CDC–N	Q,A	76.9%	77.6%	★★	↔	73.9%	86.9%
CIS–3	Q,A,T	69.1%	65.0%	★★	↔	64.4%	82.6%
IMA–1	Q,A,T	--	57.9%	--	Not Comparable	--	--
LBP	Q	79.6%	80.9%	★★	↔	72.3%	82.3%
MPM–ACE	Q	--	70.5%	--	Not Comparable	--	--
MPM–DIG	Q	--	NA	--	Not Comparable	--	--
MPM–DIU	Q	--	69.0%	--	Not Comparable	--	--
PPC–Pre	Q,A,T	82.7%	83.1%	★★	↔	80.3%	93.2%
PPC–Pst	Q,A,T	64.0%	53.1%	★	↓	59.6%	75.2%
W-34	Q,A,T	73.2%	72.0%	★★	↔	66.1%	82.9%
WCC–BMI	Q	32.6%	83.9%	★★★	↑	19.7%	69.8%
WCC–N	Q	48.9%	68.1%	★★	↑	39.0%	72.0%
WCC–PA	Q	30.2%	50.4%	★★	↑	28.5%	60.6%

[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 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

NA = A *Not Applicable* audit finding because the plan's denominator was too small.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates a new measure in 2012; the 2011 HEDIS rate is not available; and DHCS does not apply MPLs and HPLs to new measures.
★ = 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.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

Overall, Anthem had below-average performance across the eight counties for which performance measures were reported. This below-average performance is consistent with 2010 and 2011 results.

The highest-performing counties were San Francisco and Santa Clara, with San Francisco County performing above the HPLs on four measures and Santa Clara County performing above the HPLs on three measures. Although these two counties had the most rates above the HPLs, Santa Clara County had the most measures with statistically significant declines in performance (three measures) and San Francisco had two measures with statistically significant declines in performance. Additionally, each county had one measure with a rate below the MPL.

Contra Costa County had statistically significant improvement on one measure, and all other counties had statistically significant improvement on at least four measures. Stanislaus County had statistically significant improvement on the most measures, with 10 measures showing significant improvement over 2011 rates.

The poorest-performing counties were Alameda, Contra Costa, and Sacramento with rates below the MPLs on 12, 12, and 10 measures, respectively. San Joaquin, Stanislaus, and Tulare counties had rates below the MPLs on 7, 6, and 4 measures, respectively. Stanislaus and San Joaquin counties were the only two counties that did not have any measures with a statistically significant decrease in performance from 2011.

HEDIS Improvement Plans

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

Due to Anthem's poor performance related to performance measure rates, MMCD initiated a formal corrective action plan (CAP) with Anthem during the second quarter of 2011. As part of the terms of the CAP, DHCS allowed the plan to forego submission of the HEDIS improvement plans for its 2011 rates under the premise that the plan would meet the goals of the CAP. Anthem outlined two goals within the CAP:

1. Perform at or above the national 25th percentile for all HEDIS metrics across all contracts on or before HEDIS 2014.
2. For measures that are currently above the national 25th percentile, achieve "meaningful" improvement between current performance and HEDIS 2014 performance.

The plan submits quarterly updates to MMCD on CAP activities. HSAG reviewed the CAP and quarterly updates during the review period and found that Anthem has realized nominal gains since implementation of the CAP. Results show a mixture of measures either remaining constant or trending upwards or downwards, but no steady improvement can be identified across all counties or measures based on Anthem's 2012 performance.

Anthem's first goal is to perform at or above the national 25th percentile for all HEDIS measures by HEDIS 2014. HSAG's review of the plan's data found that the plan is trending in the opposite direction of its stated goal with 53 total measure rates below the 2012 MPLs when compared to 50 measures below the MPLs in 2011 and 46 in 2010. Since the measures that were included in the measure set varied across the three-year period, direct comparisons to the number of measures falling below the MPLs are not always feasible; however, Anthem's overall performance does not show an improvement.

Anthem's second goal, to achieve meaningful improvement for those measures currently above the national 25th percentile by HEDIS 2014, showed that 78 measures were assessed for meaningful improvement, with 32 measure rates meeting the goal and 46 rates still below the goal.

Anthem's CAP shows that most effort was put toward improving data capture as a strategy to improve performance measure rates. As the plan has made some progress in this area, the focus of the CAP should shift to provider and member interventions.

Subsequent to reviewing Anthem's 2012 HEDIS rates, DHCS required the plan to continue the CAP and to submit IPs for all 2012 reported measures with rates below the MPLs.

Strengths

Although Anthem continues to have below-average performance on most measures, some counties showed improvement when comparing 2012 rates to 2011 rates. HSAG's review of the plan's April 1, 2012, through June 30, 2012 quarterly CAP update identified efforts Anthem is making to improve performance on the performance measures, including provider incentive programs and activities to improve provider relationships. The plan appears to be regularly evaluating the effectiveness of the CAP activities and making changes, where needed, based on the evaluation findings.

Opportunities for Improvement

Anthem has many opportunities for improvement. While overall performance on measures is below average, some counties' performance is significantly lower than others. Alameda, Contra Costa, and Sacramento counties continue to have the greatest opportunity for improvement. For

measures where improvement was made from 2011 to 2012, HSAG recommends that Anthem assess the factors that contributed to the success, and then duplicate the efforts, as appropriate, across counties.

For measures where improvement continues to decline, HSAG recommends that Anthem assess the barriers to improve performance, identify strategies to address the barriers, and implement the strategies across counties. In addition, HSAG recommends that the plan ensure that interventions implemented are the result of a data-driven process of barrier analysis. The plan should also have an evaluation component of the interventions to determine their effectiveness. This will help aid the plan in determining which interventions to standardize and which to modify or eliminate due to ineffectiveness.

HSAG recommends that MMCD have more formal communication with Anthem and the EQRO to review Anthem's progress toward addressing its quarterly CAP reports to allow for mid-course correction if needed as a strategy to increase the likelihood of success. Additionally, since the plan has made some progress in the area of improving data capture as a strategy to improve performance measure rates, the plan should shift the focus of its CAP activities to provider and member interventions.

Finally, through development of IPs for all measures falling below the MPLs, Anthem has the opportunity to specify how it is approaching improvement for each measure in each county. HSAG recommends that the plan have in-depth discussions with MMCD and the EQRO on barrier analysis, data, and targeted interventions for those counties and measures in greatest need of improvement.

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, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

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

Anthem had two clinical QIPs and two QIP proposals in progress during the review period of July 1, 2011–June 30, 2012. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of DHCS's 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 *Improving HEDIS Postpartum Care Rates* QIP fell under the timeliness domain of care. The internal QIP proposal for Fresno, Kings, and Madera counties sought to increase HbA1c screening and retinal eye exams for members over 18 years of age. The plan also participated in the new statewide *All-Cause Readmissions* collaborative which focused on reducing readmissions for members aged 21 years and older. These two QIP proposals fell under the quality and access domains of care.

The postpartum care QIP aimed to improve the rate of postpartum visits for women between 21 and 56 days after delivery. Initial rates reported for the counties ranged between 28.8 percent and 57.4 percent. Through the use of member, provider, and system interventions, the plan's objective was to increase the outcome by three percentage points over the course of the project. Ensuring that women are seen postpartum is important to the physical and mental health of the mother.

The diabetes management QIP proposal targeted diabetic members in Fresno, Kings, and Madera counties and focused on improving HbA1c screening and retinal eye exams. Ongoing management of diabetic members is critical to preventing complications and ensuring their optimal health.

The current 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. At the initiation of the QIP, Anthem had identified 38,037 ER visits that were avoidable, which was 18.6 percent of the plan's ER visits. Anthem's objective was to reduce this rate with the use of both member and provider improvement strategies. Accessing care in a primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

The new statewide collaborative proposal focused on reducing readmissions due to all causes within 30 days of an inpatient discharge. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members, leading to improved health outcomes.

Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties July 1, 2011, through June 30, 2012

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 QIPs					
Reducing Avoidable Emergency Room Visits	Counties reported as single unit—Alameda, Contra Costa, Fresno, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare counties	Annual Submission	97%	100%	*Met*
*All-Cause Readmissions**	Counties received the same score—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare counties	Proposal	Not Applicable	Not Applicable	*Pass*
Internal QIPs					
Improving HEDIS Postpartum Care Rates	Alameda	Annual Submission	92%	100%	*Met*
	Contra Costa	Annual Submission	91%	100%	*Met*
	Fresno	Annual Submission	86%	100%	*Met*
	Sacramento	Annual Submission	86%	100%	*Met*
	San Francisco	Annual Submission	84%	100%	*Met*
	San Joaquin	Annual Submission	90%	100%	*Met*
	Santa Clara	Annual Submission	92%	100%	*Met*
	Stanislaus	Annual Submission	88%	100%	*Met*
	Tulare	Annual Submission	92%	100%	*Met*

Table 4.1—Quality Improvement Project Validation Activity for Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties July 1, 2011, through June 30, 2012

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]
Improving Diabetes Management	Counties received the same score—Fresno, Kings, and Madera counties	Proposal	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*.

*During the review period, the All-Cause Readmissions QIP was reviewed as a *Pass/Fail* only, since the project was in its study design phase.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that the annual submission by Anthem of its *Reducing Avoidable Emergency Room Visits*, *Improving HEDIS Postpartum Care Rates*, and its *Improving Diabetes Management* QIPs all received an overall validation status of *Met* with 100 percent of critical elements receiving a *Met* score. For the *All-Cause Readmissions* proposal, the plan appropriately submitted the common language developed for the study design phase and received a *Pass* score.

Due to unique one-time validation scoring used for the initial submission of the study design stage for the *All-Cause Readmissions* statewide collaborative proposal, this QIP will not be included in the following QIP validation table. Additionally, since the QIP had not progressed to the implementation stage, it will not be included in the outcomes table or discussion.

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

Table 4.2—Quality Improvement Project Average Rates* for Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties (Number = 13 QIP Submissions, 3 QIP Topics) July 1, 2011, through June 30, 2012

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)	100%	0%	0%
	VI: Accurate/Complete Data Collection	99%	0%	1%
	VII: Appropriate Improvement Strategies	78%	22%	0%
Implementation Total**		**96%**	**4%**	**1%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation**	74%	6%	21%
	IX: Real Improvement Achieved**	58%	10%	33%
	X: Sustained Improvement Achieved	100%	0%	0%
Outcomes Total		**69%**	**7%**	**24%**

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

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

Anthem submitted Activities I through V for its *Improving Diabetes Management* proposal submission. Anthem submitted Remeasurement 1 data for its *Improving HEDIS Postpartum Care Rates* QIP; therefore HSAG validated Activities I through IX. For its *Reducing Avoidable Emergency Room Visits* QIP, the plan submitted Remeasurement 3 data; so HSAG validated Activity I through Activity X for this QIP.

Anthem demonstrated a strong understanding of the design and implementation stages, scoring 100 percent *Met* for all applicable evaluation elements within five of the seven activities. For Activity VII, the plan's score was lowered due to several findings in the *Improving HEDIS Postpartum Care Rates* QIPs. The plan identified several statistically significant factors characterizing the members not receiving appropriate services, yet the plan failed to develop any interventions targeted to these members. Additionally, the plan attributed improvement for several counties to an intervention that had not been implemented during the measurement period.

For the outcomes stage, Anthem was scored lower in Activity VIII of its *Improving HEDIS Postpartum Care Rates* QIPs for not identifying whether there were factors that affected the validity of the data or the ability to compare measurement periods. Additionally, the plan did not provide a complete interpretation of the results. For Activity IX of its *Improving HEDIS Postpartum Care Rates* QIPs, the plan's scores were lowered for not achieving statistically significant improvement for five counties. For the four counties with statistically significant improvement, the plan incorrectly attributed the success to an intervention which had not been implemented during the measurement period. In Activity X, the plan achieved sustained improvement for its *Reducing Avoidable Emergency Room Visits* QIP. 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 and Interventions

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 Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties July 1, 2011, through June 30, 2012

QIP #1—Reducing Avoidable Emergency Room Visits					
QIP Study Indicator	**Baseline Period 1/1/07–12/31/07**	**Remeasurement 1 1/1/08–12/31/08**	**Remeasurement 2 1/1/09–12/31/09**	**Remeasurement 3 1/1/10–12/31/10**	**Sustained Improvement¥**
Percentage of avoidable ER visits (combined rate of all counties—Alameda, Contra Costa, Fresno, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare)	18.6%	17.7%*	19.2%*	17.8%*	Yes

Table 4.3—Quality Improvement Project Outcomes for Anthem Blue Cross Partnership Plan—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties July 1, 2011, through June 30, 2012

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	Alameda	43.3%	51.1%*	‡	‡
	Contra Costa	28.8%	43.6%*	‡	‡
	Fresno	55.7%	50.9%	‡	‡
	Sacramento	52.1%	49.9%	‡	‡
	San Francisco	57.4%	55.5%	‡	‡
	San Joaquin	48.9%	51.3%	‡	‡
	Santa Clara	55.5%	65.7%*	‡	‡
	Stanislaus	54.3%	53.7%	‡	‡
	Tulare	46.5%	64.0%*	‡	‡
QIP #3—Improving Diabetes Management					
QIP Study Indicator	**County**	**Baseline Period 1/1/12–12/31/12**	**Remeasurement 1 1/1/13–12/31/13**	**Remeasurement 2 1/1/14–12/31/14**	**Sustained Improvement¥**
Percentage of eligible members who received one or more HbA1c tests	Fresno	‡	‡	‡	‡
	Kings	‡	‡	‡	‡
	Madera	‡	‡	‡	‡
Percentage of eligible members who received a retinal eye exam	Fresno	‡	‡	‡	‡
	Kings	‡	‡	‡	‡
	Madera	‡	‡	‡	‡

¥ 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.

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

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

Reducing Avoidable Emergency Room Visits QIP

For the *Reducing Avoidable Emergency Room Visits* QIP, Anthem set an overall objective to decrease the rate of ER visits designated as avoidable by 10 percent. For this project outcome, a lower rate demonstrates improved performance. While the plan did not meet its overall objective, it was able

to reduce the percentage of avoidable ER visits by a statistically significant amount from baseline to the first remeasurement period (0.9 percentage points) and from the second remeasurement period to the third remeasurement period (1.4 percentage points). The third remeasurement period remained below baseline, demonstrating sustained improvement for the project.

While the plan did achieve statistically significant improvement for two remeasurement periods and overall sustained improvement, there was a statistically significant decline in performance from the first remeasurement period to the second remeasurement period. A critical analysis of the plan's improvement strategy identified the following:

- A project team conducted the barrier analysis, identified barriers, prioritized the barriers, and developed interventions. Although county-specific survey results were identified, the plan did not develop county-specific targeted interventions directly linked to these results. The plan identified ethnicity and language differences between the counties; however, these were predetermined factors chosen for evaluation first and then analyzed. The plan did not provide complete county-specific barrier analyses results.
- The plan primarily concentrated its plan-specific improvement strategy on its ER Program and providing access to after-hour care to reduce avoidable ER visits. For both strategies, the plan evaluated how many members were contacted; however, the plan did not evaluate the intervention's effectiveness by identifying whether members that were contacted were less likely to have subsequent avoidable ER visits than those members who were not contacted by the plan.
- The plan reported limited success with the collaborative interventions. Anthem reported that 60.7 percent of the ER visit data was received from the participating hospital on the day of the visit and the plan contacted 64.7 to 75.7 percent of the members after receiving the data. However, the avoidable ER visit rate was higher for the participating hospital than for the non-participating hospitals.

Improving HEDIS Postpartum Care Rates QIPs

For the *Improving HEDIS Postpartum Care Rates* QIPs, the plan's objective was to increase the percentage of deliveries that had a postpartum visit between 21 and 56 days after delivery by one percentage point for each measurement period. The plan met its objective for five of its nine counties. Additionally, for four of the five counties, the increase was statistically significant. A critical analysis of the plan's improvement strategy identified the following:

- The plan's quality committee conducted a brainstorming session to identify barriers and develop interventions. The plan did not provide any specific results of the barrier analyses or any data-driven rationale for the selection of the interventions.
- The plan identified ethnicity, language, age, and member residence as potential barriers within the counties; however, only age was identified through a barrier analysis of the HEDIS rates. The other barriers were predetermined factors chosen for evaluation first and then analyzed. Additionally, for the factors that were are identified as having significant differences within a

county, the plan did not develop any targeted interventions to address the barriers. The plan did not document the data analysis of any other additional factors/barriers such as provider or hospital of delivery.

- Interventions were documented without a specific evaluation plan for each intervention. Improvement documented for four counties was attributed to additional HEDIS staff without an evaluation being conducted of the intervention. Additionally, the intervention had not been implemented during the measurement period.
- The plan did not document the results of annual barrier analyses for each measurement period. Additionally, it did not change or modify its improvement strategy based on reported data analysis results.

Implementing interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources. The plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine whether to modify, discontinue, or implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

Strengths

Anthem accurately documented the QIP process as evidenced by a *Met* validation status for the annual submissions of its *Reducing Avoidable ER Visits, Improving HEDIS Postpartum Care Rates*, and *Improving Diabetes Management* QIPs.

The plan increased the percentage of appropriately timed postpartum visits for Alameda, Contra Costa, Santa Clara, and Tulare counties.

The plan was able to reduce the percentage of avoidable ER visits and sustain that improvement through the final remeasurement period.

Opportunities for Improvement

Anthem should conduct an annual barrier analysis, at minimum. The plan should improve the documentation of the barrier analysis, providing the data, the identified barriers, and the rationale for how the barriers are prioritized.

The interventions implemented should address the high priority barriers. A method to evaluate the effectiveness of each intervention should be documented, as well as the results of the intervention's evaluation for each measurement period.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care. A more detailed description of HSAG's scoring process is included in Appendix A.

Quality

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

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries 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, 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 2012 performance measure rates, QIP outcomes, and the results of the medical performance review standards related to measurement and improvement. While Anthem reports some action toward resolving the quality-related deficiency that was identified during the most recent medical performance review, the plan's annual time frame for reviewing grievances for potential continuity and coordination of care issues is likely not frequent enough to ensure quality of care issues are being timely identified and addressed.

All of Anthem's counties performed below the MPLs on at least one quality performance measure. The plan is on a formal CAP with DHCS based on continued poor performance on its quality of care measures. Based on 2011 rates, Alameda and Contra Costa counties had the greatest opportunity for improvement related to quality of care based on the number of measures that fell below the MPLs (11 and 13, respectively). Alameda and Contra Costa counties continue to show the greatest opportunity for improvement based on each of these counties having 12 measures falling below the 2012 MPLs. Although Sacramento County showed some improvement in its overall performance in 2011, the number of measures performing below the MPLs in 2012 increased from 8 to 10 measures and, therefore, also presents an opportunity for improvement.

Stanislaus County had statistically significant improvement on the most measures (10) and zero measures with a statistically significant decline in performance. This county also had two less measures performing below the MPLs in 2012 than it did in 2011.

All of Anthem's counties exceeded the MPL for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total*. The top-performing counties were San Francisco and Santa Clara. San Francisco County had four rates above the HPLs and one rate below the MPL. Santa Clara County had three rates above the HPLs and one rate below the MPL.

Anthem's *Improving HEDIS Postpartum Care Rates* QIP resulted in four of the nine counties (Alameda, Contra Costa, Santa Clara, and Tulare) having statistically significant improvement in the percentage of women who had a postpartum visit between 21 and 56 days after delivery. Despite the improvement seen in four of the nine counties, the plan lacked results of the barrier analyses and any data-driven rationale for the selection of the interventions. In addition, the plan did not provide an evaluation of the effectiveness of the interventions. These additional components may help increase the likelihood of success for more counties and/or help to differentiate the unique differences of the counties for more targeted interventions.

Anthem continues to struggle with its performance related to the quality domain. While Anthem reports on many efforts being implemented as part of the plan's CAP required by DHCS, improvements were not evidenced during the reporting period for the quality of care measures. If minimal improvements continue to be made, it is recommended that 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 MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and 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.

Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes 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 beneficiaries 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 2012 performance measure rates, QIP outcomes, and results of the medical performance review standards related to the availability of and access to care. While Anthem reports activities toward resolving some of the access-related deficiencies that were identified in the plan's most recent medical performance review and MR/PIU review, HSAG could not locate documentation providing evidence that Anthem has fully addressed all access-related deficiencies.

Anthem's 2012 performance measure rates showed mixed results and overall minimal improvements in the area of access. Although Anthem did not meet the plan's overall objective to decrease the rate of ER visits designated as avoidable by 10 percent, Anthem demonstrated sustained improvement on the *Reducing Avoidable Emergency Room Visits* QIP at the third remeasurement. The sustained improvement suggests that the plan was effective with having members access care in a setting other than the ER.

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.

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 2012 performance measure rates for providing timely care.

All of Anthem's counties except San Francisco 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, which was also true in 2011.

As previously noted by HSAG, Anthem demonstrated strength 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.

Anthem's poor performance in the timeliness of care domain is related to performance measure results rather than health plan operations. As with the quality and access measures, there is much room for improvement in the plan's performance on the timeliness measures.

Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. Anthem's self-reported responses are included in Appendix B.

Recommendations

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

- Continue to monitor activities to ensure that actions are taken to fully address areas of deficiency identified through the medical performance review and findings from the MR/PIU review and that the plan documents, tracks, and monitors its compliance.
- Continue to work closely with DHCS on implementation and monitoring of the CAP, including conducting ongoing assessment of progress and making changes when indicated.
- Work to capture the rendering provider type on all service data and consider making vendor contract changes to reflect the requirements moving forward.
- Work with HSAG when developing additional supplemental sources of data to ensure the data sources meet NCQA reporting requirements.

- For measures where improvement was made from 2011 to 2012, assess the factors that contributed to the success and duplicate the efforts, as appropriate, across counties.
- For measures where improvement continues to decline, assess the barriers to improved performance, identify strategies to address the barriers, and implement the strategies across counties.
- Conduct an annual QIP barrier analysis, at minimum, and improve documentation of the barrier analysis, providing the data, the identified barriers, and the rationale for how the barriers are prioritized.
- Ensure that QIP interventions address the high priority barriers and document a method to evaluate the effectiveness of each intervention, including the results of the intervention's evaluation for each measurement period.

In addition to the recommendations to the plan, HSAG recommends that DHCS implements a more formal process to assess the plan's progress on the CAP, including a more detailed focus on the interventions and strategies to improve performance measure rates.

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

Quality, Access, and Timeliness

Scale
2.5–3.0 = Above Average
1.5–2.4 = Average
1.0–1.4 = Below Average

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in the areas of quality, access, and timeliness domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Tables 3.2 through 3.9)

Quality Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) greater than negative three, if there are two or less measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than three.
3. To be considered ***Below Average***, a plan will have three or more measures below the MPLs than it has above the HPLs.

Access Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus and the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Timeliness Domain

1. To be considered ***Above Average***, a plan cannot have more than two measures below the MPLs. Also, the plan must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered ***Average***, a plan must have an MPL and HPL net difference (i.e., the number of measures below the MPLs minus the number of measures above the HPLs) no greater than negative two, if there are two or fewer measures below the MPLs. Or, if there are three or more measures below the MPLs, then the plan must have an MPL and HPL net difference of less than two.
3. To be considered ***Below Average***, a plan will have two or more measures below the MPLs than it has above the HPLs.

Quality Improvement Projects (QIPs)

(Refer to Tables 4.1 and 4.3)

- **Validation** *(Table 4.1)*: For each QIP submission and subsequent resubmission(s), if applicable.
  - **Above Average** is not applicable.
  - **Average** = *Met* validation status.
  - **Below Average** = *Partially Met* or *Not Met* validation status.
- **Outcomes** *(Table 4.3)*: Activity IX, Element 4—**Real Improvement**
  - **Above Average** = All study indicators demonstrated statistically significant improvement.
  - **Average** = Not all study indicators demonstrated statistically significant improvement.
  - **Below Average** = No study indicators demonstrated statistically significant improvement.

- **Sustained Improvement** *(Table 4.3)*: Activity X—**Achieved Sustained Improvement**
  - **Above Average =** All study indicators achieved sustained improvement.
  - **Average =** Not all study indicators achieved sustained improvement.
  - **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical performance reviews and MR/PIUs did not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of this activity is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain.

Appendix B. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

for Anthem Blue Cross Partnership Plan

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with Anthem's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table B.1—Grid of Anthem's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	Anthem's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Continue to incorporate medical performance review deficiencies in the internal quality improvement work plan to ensure that they are addressed and monitored.	The Plan incorporated Corrective Action Plan monitoring into the Quality Improvement Work Plan following this recommendation. The Quality Improvement Work Plans for both 2011 and 2012 include corrective action plan monitoring activities to ensure that actions are taken to address areas of deficiency; and to ensure opportunities for improvement are documented, tracked, and monitored for compliance. The plan will continue to utilize our Quality Improvement Work Plan to review/monitor medical performance deficiencies.
Continue to work closely with DHCS on implementation and monitoring of the HEDIS CAP.	A corrective action plan (CAP) was written and final submission to the State was July 7, 2011. The State approved our CAP submission. We have monthly [internal] meetings to monitor the progress of the activities outlined in the CAP. Quarterly updates are provided to the state. These quarterly updates were submitted on October 31, 2011, January 31, 2012, April 30, 2012, and are ongoing through the present date.
Continue efforts to improve the completeness of encounter data submissions and implement a process to monitor monthly provider volume to identify missing data sources.	Anthem's Encounter Data Management and Reporting unit will continue to compile and monitor monthly encounter volumes from its contracted capitated groups in 2013 as it has done in prior measurement years and as part of its overall HEDIS continual program improvement efforts. The encounter management reports provide key information related to data completeness and submission timeliness that will be leveraged and utilized in root cause analysis related to low HEDIS scores by allowing Anthem to determine if submission of encounter data could be a factor necessitating further action or conversely, to rule out the receipt of encounter data as a potential cause. This information and data allow Anthem to effectively and appropriately focus its root cause analysis efforts with regard to underperforming counties, capitated medical group, or HEDIS measures. Anthem's Encounter Unit will also continue to work collaboratively with its Provider Engagement and Contracting areas to review group encounter submission performance on an ongoing basis. Identified capitated group reporting deficiencies are addressed jointly by the Encounter area and Provider Engagement area to determine root cause of issues which may be a result of capitated groups' business process, system, or compliance issues.
Explore the use of PM-160 data as a supplemental data source that may help to improve performance measure rates.	A work group has been established to explore the use of PM-160 data. The Revenue Team has assigned a project manager to work on a solution for 2013, including evaluating accuracy of the data, provider education, electronic tracking and documentation of PM-160 data, vendor quality oversight, etc. We will continue to monitor the progress of the project team and re-evaluate our use of the PM160 data.
Dedicate plan resources specific to the Medi-Cal managed care contract to increase the likelihood of success in improving performance.	The implementation of a policy to utilize qualified non-RN temporary staffing to collect and abstract HEDIS chart data resulted in an increase from 24 temporary staff for the 2010 collection cycle to 46 temporary staff for the 2011 cycle.