# Performance Evaluation Report

## Anthem Blue Cross Partnership Plan

July 1, 2012–June 30, 2013

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

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# 1. INTRODUCTION

## Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

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 provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction

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

survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Anthem Blue Cross Partnership Plan ("Anthem" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

## Managed Care Plan Overview

Anthem, formerly Blue Cross of California prior to April 1, 2008, operated in 10 counties during the July 1, 2012, through June 30, 2013, review period for this report and in two counties from July 1, 2012, through December 31, 2012. Anthem, a full-scope MCP, delivers care to members under the Two-Plan Model (TPM) in all counties except Sacramento, in which care is delivered under the Geographic Managed Care (GMC) model. In the GMC model, DHCS allows MCMC beneficiaries to select from several commercial MCPs within a specified geographic area.

Anthem delivers services to its MCMC members as a "Local Initiative" (LI) and "commercial plan" (CP) MCP under the TPM. In most TPM counties, there is an LI and a CP. DHCS contracts with both plans. The LI is designed—with the input of local government, community groups, and health care providers—to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. MCMC beneficiaries may enroll in a CP MCP, or in the alternative LI. The following table shows the counties in which Anthem provided services to MCMC beneficiaries under the TPM and denotes which MCP is the CP and which is the LI for each county. Note: San Joaquin and Stanislaus counties are not included in the table. Anthem stopped providing services to MCMC beneficiaries in these two counties on December 31, 2012.

| County | Commercial Plan | Local Initiative Plan |
|---|---|---|
| Alameda | Anthem | Alameda Alliance for Health |
| Contra Costa | Anthem | Contra Costa Health Plan |
| Fresno | Anthem | CalViva Health |
| Kings | Anthem | CalViva Health |
| Madera | Anthem | CalViva Health |
| San Francisco | Anthem | San Francisco Health Plan |
| Santa Clara | Anthem | Santa Clara Family Health Plan |
| Tulare | Health Net Community Solutions, Inc. | Anthem |

Anthem became operational in Sacramento County to provide MCMC services effective in 1994 with expansion into additional counties occurring in subsequent years—Alameda, Contra Costa, Fresno, San Francisco, and Santa Clara counties in 1996 and Tulare County 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 indicated above, as of December 31, 2012, Anthem stopped providing services to MCMC members in San Joaquin and Stanislaus counties. As of December 31, 2012, San Joaquin County had 22,380 MCMC members and Stanislaus County had 49,277 MCMC members. As of June 30, 2013, Anthem had 35,462 MCMC members in Alameda County, 14,929 members in Contra Costa County, 73,280 members in Fresno County, 14,103 members in Kings County, 13,371 members in Madera County, 101,009 members in Sacramento County, 15,006 members in San Francisco County, 41,325 members in Santa Clara County, and 77,105 members in Tulare County—for a total of 385,590 MCMC members.[3]

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

## Conducting the EQRO Review

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

This report section 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, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

## Assessing the State's Compliance Review Activities

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.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP'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. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

### *Readiness Reviews*

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

### Medical Performance Audits and Member Rights Reviews

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

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

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

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

DHCS did not conduct any audits or reviews with Anthem during the review period for this report. In Anthem's 2011–12 MCP-specific evaluation report, HSAG provided a summary of the status of unresolved deficiencies from the September 2009 DMHC medical performance review and unresolved findings from the May 2009 Member Rights/Program Integrity Unit (MR/PIU) review conducted with Anthem. In the 2011–12 MCP-specific evaluation report, HSAG recommended

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

that Anthem continue to monitor activities to ensure that the unresolved deficiencies and findings were addressed and that the MCP had a process to document, track, and monitor its progress. As part of the process for producing Anthem's 2012–13 MCP-specific evaluation report, the MCP was asked to document actions it had taken in response to each recommendation from the 2011–12 MCP-specific evaluation report. Anthem's self-report indicated that the MCP monitors ongoing activities and makes every effort to promptly address areas of deficiency. Anthem indicated that the methods used to correct deficiencies may vary depending on the nature of the deficiency and include:

- Timely implementation of any process changes in response to a statute, regulation, or regulatory agency action.
- Mailing member notices or benefit change letters to inform members when there is a substantive change to how their plan works or if benefits are added or deleted from the benefit package.

## Strengths

In response to HSAG's recommendation from the MCP's 2011–12 MCP-specific evaluation report, Anthem provided a description of the process used by the MCP to document, track, and monitor the MCP's progress on addressing unresolved deficiencies and findings.

## Opportunities for Improvement

Since no new reviews were conducted with Anthem during the reporting period, HSAG does not have any new recommendations for Anthem in the area of compliance.

## Conducting the EQRO Review

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

HSAG conducts validation of the External Accountability Set performance measures as required by DHCS to evaluate the accuracy of the MCPs' reported results. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

## Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[5] The CMS EQR Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

## Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

## Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for Anthem Blue Cross Partnership Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that Anthem followed the appropriate specifications to produce valid rates. A review of the MCP's HEDIS audit report revealed the following observations:

- Based on a recommendation from the 2012 HEDIS audit, Anthem began to investigate a way to link baby claims billed under the mother to the baby once the baby receives his or her own identification number. Linking the claims will help Anthem capture immunization and well-child visit data administratively when these services occur during the first 60 days of life.
- Anthem had the appropriate documentation for all supplemental immunization data except the pneumococcal vaccine. The MCP determined there was an issue with loading the data and therefore opted to abstract the immunization data as medical record review. HSAG reviewed these data in addition to the cases selected for medical record review, and no issues were identified.

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

- Anthem noted that dual-eligible members were excluded for all measures, and it was determined that excluded members included dual-eligible members for which Anthem was also the Medicare provider. The MCP determined the number of dual-eligible members excluded from the population, and the auditor determined there was no significant bias to the eligible population. The auditor noted that the exclusion of the dual-eligible members caused minimal impact on the findings.

## Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

**Table 3.1—Name Key for Performance Measures in External Accountability Set**

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

**Table 3.1—Name Key for Performance Measures in External Accountability Set**

| Performance Measure Abbreviation | Full Name of 2013 Reporting Year† 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* |

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.
‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Tables 3.2 through 3.12 below present a summary of Anthem's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data). Since 2013 was the first year that Anthem reported rates for Fresno, Kings, and Madera counties, no performance comparison information is included in the tables for these counties.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Tables 3.2 through 3.12 show the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

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.

**Table 3.2—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Alameda County**

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

**Table 3.2—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Alameda County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| WCC–BMI | Q | 44.04% | 62.29% | ★★ | ↑ | 29.20% | 77.13% |
| WCC–N | Q | 62.04% | 61.07% | ★★ | ↔ | 42.82% | 77.61% |
| WCC–PA | Q | 31.14% | 37.47% | ★★ | ↔ | 31.63% | 64.87% |

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

**Table 3.3—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Contra Costa County**

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

**Table 3.3—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Contra Costa County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| WCC–BMI | Q | 42.58% | 57.66% | ★★ | ↑ | 29.20% | 77.13% |
| WCC–N | Q | 53.77% | 52.31% | ★★ | ↔ | 42.82% | 77.61% |
| WCC–PA | Q | 25.55% | 36.74% | ★★ | ↑ | 31.63% | 64.87% |

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

**Table 3.4—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Fresno County**

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

**Table 3.4—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Fresno County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| WCC–BMI | Q | -- | 58.88% | ★★ | Not Comparable | 29.20% | 77.13% |
| WCC–N | Q | -- | 63.02% | ★★ | Not Comparable | 42.82% | 77.61% |
| WCC–PA | Q | -- | 46.23% | ★★ | Not Comparable | 31.63% | 64.87% |

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

**Table 3.5—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Kings County**

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

**Table 3.5—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Kings County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| WCC–BMI | Q | -- | 46.47% | ★★ | Not Comparable | 29.20% | 77.13% |
| WCC–N | Q | -- | 44.04% | ★★ | Not Comparable | 42.82% | 77.61% |
| WCC–PA | Q | -- | 31.39% | ★ | Not Comparable | 31.63% | 64.87% |

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

**Table 3.6—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Madera County**

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

**Table 3.6—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Madera County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| WCC–BMI | Q | -- | 77.62% | ★★★ | Not Comparable | 29.20% | 77.13% |
| WCC–N | Q | -- | 70.07% | ★★ | Not Comparable | 42.82% | 77.61% |
| WCC–PA | Q | -- | 48.66% | ★★ | Not Comparable | 31.63% | 64.87% |

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

**Table 3.7—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Sacramento County**

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

**Table 3.7—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Sacramento County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| WCC–BMI | Q | 63.02% | 65.45% | ★★ | ↔ | 29.20% | 77.13% |
| WCC–N | Q | 71.29% | 69.34% | ★★ | ↔ | 42.82% | 77.61% |
| WCC–PA | Q | 39.42% | 44.53% | ★★ | ↔ | 31.63% | 64.87% |

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

**Table 3.8—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—San Francisco County**

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

**Table 3.8—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—San Francisco County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| WCC–BMI | Q | 73.24% | 60.06% | ★★ | ↓ | 29.20% | 77.13% |
| WCC–N | Q | 79.32% | 72.99% | ★★ | ↓ | 42.82% | 77.61% |
| WCC–PA | Q | 71.78% | 65.52% | ★★★ | ↔ | 31.63% | 64.87% |

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

**Table 3.9—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—San Joaquin County**

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

**Table 3.9—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—San Joaquin County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| WCC–BMI | Q | 63.50% | 62.09% | ★★ | ↔ | 29.20% | 77.13% |
| WCC–N | Q | 81.51% | 79.05% | ★★★ | ↔ | 42.82% | 77.61% |
| WCC–PA | Q | 60.34% | 61.60% | ★★ | ↔ | 31.63% | 64.87% |

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).

[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

[3] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.

[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.

[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.

[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.

[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

‡ This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.

-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.

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

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

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

↓ or ▼ = Statistically significant decline.

↔ = No statistically significant change.

↑ or ▲ = Statistically significant improvement.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

**Table 3.10—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Santa Clara County**

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

**Table 3.10—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Santa Clara County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| WCC–BMI | Q | 53.28% | 55.23% | ★★ | ↔ | 29.20% | 77.13% |
| WCC–N | Q | 70.56% | 65.94% | ★★ | ↔ | 42.82% | 77.61% |
| WCC–PA | Q | 38.44% | 50.36% | ★★ | ↑ | 31.63% | 64.87% |

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

**Table 3.11—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Stanislaus County**

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

**Table 3.11—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Stanislaus County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| WCC–BMI | Q | 49.64% | 47.93% | ★★ | ↔ | 29.20% | 77.13% |
| WCC–N | Q | 63.02% | 53.53% | ★★ | ↓ | 42.82% | 77.61% |
| WCC–PA | Q | 37.23% | 43.07% | ★★ | ↔ | 31.63% | 64.87% |

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

**Table 3.12—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Tulare County**

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

**Table 3.12—Comparison of 2012 and 2013 Performance Measure Results**
**Anthem—Tulare County**

| Performance Measure[1] | Domain of Care[2] | 2012 Rates[3] | 2013 Rates[4] | Performance Level for 2013 | Performance Comparison[5] | DHCS's Minimum Performance Level[6] | DHCS's High Performance Level (Goal)[7] |
|---|---|---|---|---|---|---|---|
| WCC–BMI | Q | 83.94% | 81.51% | ★★★ | ↔ | 29.20% | 77.13% |
| WCC–N | Q | 68.13% | 64.23% | ★★ | ↔ | 42.82% | 77.61% |
| WCC–PA | Q | 50.36% | 47.93% | ★★ | ↔ | 31.63% | 64.87% |

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

## Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[8] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The

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

selection team considered conditions seen frequently in the senior population and reflected in measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Tables 3.13 through 3.34, which present a summary of Anthem's 2013 SPD measure results. The first table for each county presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. The second table for each county presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

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

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Tables 3.13, 3.15, 3.17, 3.19, 3.21, 3.23, 3.25, 3.27, 3.29, 3.31, and 3.33.

**Table 3.13—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**Anthem—Alameda County**

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

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.14—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**Anthem—Alameda County**

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

*Member months are a member's "contribution" to the total yearly membership.

**Table 3.15—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**Anthem—Contra Costa County**

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

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.16—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**Anthem—Contra Costa County**

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

*Member months are a member's "contribution" to the total yearly membership.

**Table 3.17—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**Anthem—Fresno County**

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

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.18—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**Anthem—Fresno County**

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

*Member months are a member's "contribution" to the total yearly membership.

**Table 3.19—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**Anthem—Kings County**

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

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.20—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**Anthem—Kings County**

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

*Member months are a member's "contribution" to the total yearly membership.

**Table 3.21—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**Anthem—Madera County**

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

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.22—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**Anthem—Madera County**

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

*Member months are a member's "contribution" to the total yearly membership.

**Table 3.23—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**Anthem—Sacramento County**

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

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.24—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**Anthem—Sacramento County**

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

*Member months are a member's "contribution" to the total yearly membership.

**Table 3.25—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**Anthem—San Francisco County**

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

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.26—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**Anthem—San Francisco County**

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

*Member months are a member's "contribution" to the total yearly membership.

**Table 3.27—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**Anthem—San Joaquin County**

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

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.28—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**Anthem—San Joaquin County**

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

*Member months are a member's "contribution" to the total yearly membership.

**Table 3.29—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**Anthem—Santa Clara County**

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

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.30—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**Anthem—Santa Clara County**

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

*Member months are a member's "contribution" to the total yearly membership.

**Table 3.31—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**Anthem—Stanislaus County**

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

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.32—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**Anthem—Stanislaus County**

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

*Member months are a member's "contribution" to the total yearly membership.

**Table 3.33—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population**
**Anthem—Tulare County**

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

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.34—2013 Non-SPD and SPD Rates for Ambulatory Care Measures**
**Anthem—Tulare County**

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

*Member months are a member's "contribution" to the total yearly membership.

## Performance Measure Result Findings

For the fourth consecutive year, Anthem had below-average performance across all counties for which performance measures were reported. Across all counties, the rates for 12 measures were above the HPLs, and the rates for 123 measures were below the MPLs. As in 2012, the highest-performing counties in 2013 were San Francisco and Santa Clara; however, both counties had fewer measures with rates above the HPLs and more measures with rates below the MPLs when compared to 2012. Additionally, both counties had more measures with rates that declined significantly when compared to 2012. Contra Costa County had the most measures (9) with rates that improved significantly from 2012 to 2013 and no measures with rates that declined significantly from 2012 to 2013; however, this county had 16 measures with rates below the MPLs in 2013.

Although Anthem has some areas of strength, overall, it continues to have many opportunities for improvement related to performance on required measures.

### Seniors and Persons with Disabilities Findings

For all counties except Sacramento County, the SPD rates for most measures stratified for the SPD population were similar to the non-SPD rates. In Sacramento County, the SPD rates for eight measures were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of this population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. Additionally, the SPD rate for the *All-Cause Readmissions* measure in Sacramento County was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population. The SPD rates for the *All-Cause Readmissions* measure in Alameda, Fresno, Madera, San Joaquin, Stanislaus, and Tulare counties were also significantly higher than the non-SPD rates.

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however, rates should be interpreted with caution as high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures, and HSAG does not provide comparative analysis.

## Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to

develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

Due to Anthem's below-average performance related to performance measure rates, DHCS initiated a formal corrective action plan (CAP) with the MCP during the second quarter of 2011. As part of the terms of the CAP, DHCS allowed the MCP to forego submission of the HEDIS improvement plans for its 2011 rates under the premise that the MCP 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.

In Anthem's 2011–12 MCP-specific evaluation report, HSAG indicated that its review of the MCP's CAP and quarterly CAP updates found that Anthem realized nominal gains since implementation of the CAP. Results showed a mixture of measures either remaining constant or trending upwards or downwards, but no steady improvement could be identified across all counties or measures based on Anthem's 2012 performance. Subsequent to reviewing Anthem's 2012 HEDIS rates, DHCS required the MCP to continue the CAP and to submit IPs for all 2012 reported measures with rates below the MPLs. DHCS found Anthem's IPs poorly designed, and none of the MCP's IPs were approved.

On June 4, 2013, DHCS and HSAG held a technical assistance call with Anthem to provide the MCP with guidance in development of its 2012 HEDIS IPs. DHCS and HSAG strongly emphasized that the MCP is required to develop barrier analyses that are data driven and identify barriers that are unique to each county requiring a HEDIS IP. Additionally, DHCS and HSAG stressed the importance of the MCP focusing on its strongest interventions. Finally, DHCS and HSAG emphasized the importance of Anthem incorporating rapid cycle improvement strategies capable of measuring outcome changes every two-to-three months so that the MCP can make modifications to ensure the progress made toward outcome goals is maintained. DHCS instructed

Anthem to resubmit one IP before resubmitting the remaining IPs so DHCS could assess the MCP's understanding of the concepts discussed during the technical assistance call before providing approval for the remaining IPs to be submitted.

Since the resubmission and review of the IPs occurred outside the review period for this report, HSAG will provide a summary of the status of the IPs in Anthem's 2013–14 MCP-specific evaluation report.

## Strengths

During the 2013 HEDIS audit with Anthem, HSAG auditors determined that the MCP followed the appropriate specifications to produce valid rates. Additionally, based on a recommendation made during the 2012 HEDIS audit, Anthem began to investigate a way to link baby claims billed under the mother to the baby once the baby receives his or her own identification number. Linking the claims will help Anthem capture immunization and well-child visit data administratively when these services occur during the first 60 days of life.

Although Anthem continues to have below-average performance on many measures, HSAG noted the following strengths:

- The rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in San Francisco County has been above the HPL for five consecutive years.
- The rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total* measure in San Joaquin County has been above the HPL for three consecutive years.
- The rates for the following measures have been above the HPLs for two consecutive years:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*—Alameda County
  - *Use of Imaging Studies for Low Back Pain*—Alameda, Sacramento, and Santa Clara counties
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*—Tulare County
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total*—San Francisco County
- The rates for nine measures in Contra Costa County, five measures in Tulare County, four measures in Sacramento County, three measures in Santa Clara County, two measures in Alameda County, and two measures in San Joaquin County improved significantly from 2012 to 2013.

## Opportunities for Improvement

Anthem continues to have many opportunities for improvement. As has been noted in previous years, for measures where improvement was made from the prior year, Anthem has the opportunity to assess the factors contributing to the success and duplicate the efforts, as appropriate, across counties. For measures where improvement continues to decline, Anthem has the opportunity to assess the barriers to improving performance, prioritize the barriers, and identify rapid cycle improvement strategies that will target the barriers. Additionally, Anthem has the opportunity to incorporate at least quarterly evaluation of progress so that the MCP can modify, eliminate, or add strategies to ensure improvement.

Finally, Anthem has the opportunity to continue to work with DHCS and the EQRO on identifying effective ways to approach improvement efforts, including using data to drive the barrier analysis process, identifying improvement strategies designed to make the greatest impact, and ensuring ongoing evaluation of improvement strategies.

## Conducting the EQRO 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 CMS validation protocol[10] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county.

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* 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 MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

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

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

[10] The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

## Quality Improvement Project Objectives

Anthem participated in the statewide collaborative QIP and had two internal QIPs in progress during the review period of July 1, 2012–June 30, 2013.

Table 4.1 below lists Anthem's QIPs and indicates the counties in which the QIP is being conducted, whether the QIP is clinical or nonclinical, and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for Anthem**
**July 1, 2012, through June 30, 2013**

| QIP | Counties | Clinical/Nonclinical | Domains of Care |
|---|---|---|---|
| *All-Cause Readmissions* | All | Clinical | Q, A |
| *Improving HEDIS Postpartum Care Rates* | Alameda, Contra Costa, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare | Clinical | Q, A |
| *Improving Diabetes Management* | Alameda and Contra Costa | Clinical | Q, A |

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. 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.

Prior to initiation of the statewide collaborative QIP, Anthem's counties had 30-day readmission rates between 9.20 percent and 13.09 percent among Medi-Cal beneficiaries. Anthem also found that the MCP's readmission rates for the SPD population were between 13.64 percent and 16.62 percent. These rates were higher than the non-SPD population rates, which were between 6.50 percent and 10.83 percent.

The *Improving HEDIS Postpartum Care Rates* 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 from between 28.8 percent and 57.4 percent. Using member, provider, and system interventions, the MCP's objective was to increase the outcome by 3 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 *Improving Diabetes Management* QIP study design submission targeted diabetic members in Alameda and Contra Costa 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.

## Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity**
**Anthem—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties**
**July 1, 2012, through June 30, 2013**

| Name of Project/Study | Counties | Type of Review[1] | Percentage Score of Evaluation Elements *Met*[2] | Percentage Score of Critical Elements *Met*[3] | Overall Validation Status[4] |
|---|---|---|---|---|---|
| **Statewide Collaborative QIP** | | | | | |
| *All-Cause Readmissions* | Counties received the same score—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare | Study Design Submission | 80% | 100% | *Met* |
| **Internal QIPs** | | | | | |
| *Improving HEDIS Postpartum Care Rates* | Alameda | Annual Submission | 97% | 100% | *Met* |
| | Contra Costa | Annual Submission | 100% | 100% | *Met* |
| | Sacramento | Annual Submission | 94% | 100% | *Met* |
| | San Francisco | Annual Submission | 93% | 100% | *Met* |
| | San Joaquin | Annual Submission | 91% | 100% | *Met* |
| | Santa Clara | Annual Submission | 94% | 100% | *Met* |
| | Stanislaus | Annual Submission | 94% | 100% | *Met* |
| | Tulare | Annual Submission | 94% | 100% | *Met* |
| *Improving Diabetes Management* | Counties received the same score—Alameda and Contra Costa | Study Design Submission | 64% | 67% | *Not Met* |
| | | Study Design Resubmission 1 | 80% | 67% | *Partially Met* |
| | | Study Design Resubmission 2 | 100% | 100% | *Met* |

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

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

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

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

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by Anthem of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 80 percent of evaluation elements met. Anthem also received an overall validation status of *Met* for its *Improving HEDIS Postpartum Care Rates* annual submission with 100 percent of critical elements being met and between 91 percent and 100 percent of evaluation elements being met based on county scores. Finally, Anthem received a *Not Met* validation status for its *Improving Diabetes Management* study design submission. As of July 1, 2009, DHCS has required MCPs to resubmit their study designs until they have achieved an overall *Met* validation status. Anthem resubmitted the study design two times and the second resubmission achieved an overall *Met* validation status with 100 percent of both the critical and evaluation elements being met.

Table 4.3 summarizes the aggregated validation results for Anthem's QIPs across CMS protocol activities during the review period.

**Table 4.3—Quality Improvement Project Average Rates***
**Anthem— Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties**
**(Number = 5 QIP Submissions, 3 QIP Topics)**
**July 1, 2012, through June 30, 2013**

| QIP Study Stages | Activity | *Met* Elements | *Partially Met* Elements | *Not Met* Elements |
|---|---|---|---|---|
| Design | I: Appropriate Study Topic | 100% | 0% | 0% |
| | II: Clearly Defined, Answerable Study Question(s) | 100% | 0% | 0% |
| | III: Clearly Defined Study Indicator(s) | 100% | 0% | 0% |
| | IV: Correctly Identified Study Population | 84% | 16% | 0% |
| | V: Valid Sampling Techniques (if sampling is used) | 96% | 0% | 4% |
| | VI: Accurate/Complete Data Collection** | 75% | 5% | 21% |
| **Design Total**** | | **88%** | **3%** | **8%** |
| Implementation | VII: Sufficient Data Analysis and Interpretation | 100% | 0% | 0% |
| | VIII: Appropriate Improvement Strategies | 100% | 0% | 0% |
| **Implementation Total** | | **100%** | **0%** | **0%** |
| Outcomes | IX: Real Improvement Achieved** | 63% | 0% | 38% |
| | X: Sustained Improvement Achieved | 50% | 0% | 50% |
| **Outcomes Total** | | **61%** | **0%** | **39%** |

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

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

HSAG validated Activities I through VI for Anthem's *All-Cause Readmissions* and *Improving Diabetes Management* study design submissions and Activities I through X for the MCP's *Improving HEDIS Postpartum Care Rates* QIP annual submission.

Anthem demonstrated a strong application of the Design stage, meeting 88 percent of the requirements for all applicable evaluation elements within the study stage for all three QIPs. In the *All-Cause Readmissions* QIP, Anthem did not provide documentation of a clearly defined and systematic process for collecting baseline and remeasurement data or describe the MCP's data analysis plan, resulting in a lower score for Activity VI. In the submission and first resubmission of the *Improving Diabetes Management* QIP, the MCP did not provide all required documentation for Activities IV and V, resulting in lower scores for these activities. Additionally, the MCP did not include information on the type of medical/treatment records to be used, specify how it will perform manual data collection, include required information on the data collection tool, or describe the data analysis plan, resulting in a lower score for Activity VI. The MCP corrected the issues in its second resubmission, receiving a fully *Met* validation status on the QIP. For the *Improving HEDIS Postpartum Care Rates* QIP, Anthem met all requirements for all applicable evaluation elements within the Design stage.

The *Improving HEDIS Postpartum Care Rates* QIP is the only QIP that progressed to the Implementation and Outcomes stages. The MCP demonstrated excellent application of the Implementation stage, meeting 100 percent of the requirements for all applicable evaluation elements within this stage for this QIP. The QIP results for the Outcomes stage varied between counties:

- Contra Costa County met 100 percent of the requirements for all applicable evaluation elements for the Outcomes stage, and the study indicator achieved statistically significant and sustained improvement over baseline. The study indicator in Alameda County also achieved statistically significant and sustained improvement over baseline; however, the indicator showed a slight decline in performance at Remeasurement 2, resulting in a lower score for Activity IX.
- Although the study indicators for Santa Clara and Tulare counties achieved statistically significant improvement over baseline at Remeasurement 1, the indicators in both counties demonstrated a decline in performance from Remeasurement 1 to Remeasurement 2, with the decline in Tulare County being statistically significant. The decline in performance and the fact that the indicators did not maintain the statistically significant improvement that was documented at Remeasurement 1 resulted in lower scores for Activities IX and X.
- Activity IX in Sacramento, San Francisco, San Joaquin, and Stanislaus counties received lower scores because the study indicators in these counties did not demonstrate statistically significant improvement over baseline. Activity X was not assessed for these counties since sustained improvement cannot be assessed until the indicator has achieved statistically significant improvement over baseline.

## Quality Improvement Project Outcomes and Interventions

Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

Since the *All-Cause Readmissions* and *Improving Diabetes Management* QIPs did not progress to the Implementation or Outcomes stage during the reporting period, no intervention or outcome information is included in this report.

**Table 4.4—Quality Improvement Project Outcomes for Anthem—Alameda, Contra Costa, Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties July 1, 2012, through June 30, 2013**

| QIP #1—Improving HEDIS Postpartum Care Rates | | | | |
|---|---|---|---|---|
| **Study Indicator:** Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery | | | | |
| **County** | **Baseline Period 1/1/09–12/31/09** | **Remeasurement 1 1/1/10–12/31/10** | **Remeasurement 2 1/1/11–12/31/11** | **Sustained Improvement¥** |
| Alameda | 43.3% | 51.1%* | 50.6% | Yes |
| Contra Costa | 28.8% | 43.6%* | 48.2% | Yes |
| Sacramento | 52.1% | 49.9% | 54.3% | ‡ |
| San Francisco | 57.4% | 55.5% | 64.0% | ‡ |
| San Joaquin | 48.9% | 51.3% | 48.2% | ‡ |
| Santa Clara | 55.5% | 65.7%* | 60.6% | No |
| Stanislaus | 54.3% | 53.7% | 56.7% | ‡ |
| Tulare | 46.5% | 64.0%* | 53.1%** | No |

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

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

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

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

### *Improving HEDIS Postpartum Care Rates* QIP

For the *Improving HEDIS Postpartum Care Rates* QIP, Anthem's objective was to increase the percentage of deliveries that had a postpartum visit between 21 and 56 days after delivery by 1 percentage point for each measurement period. The MCP had varying results between the counties. Additionally, two of the MCP's counties achieved statistically significant and sustained improvement for the study indicator at Remeasurement 2. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- Anthem documented that the MCP completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process.
- Anthem included a description about the success of quality improvement actions and how the interventions were standardized and monitored as a result of those actions.
- Anthem implemented several interventions in the second half of 2011, which may have not allowed enough time for the interventions to affect the outcomes.
- Anthem documented using a one-tailed statistical test. HSAG provided feedback to the MCP that it should not use a one-tailed test and that a two-tailed Chi-square, Fisher's exact, or $z$ test for proportions should be used for all statistical testing as indicated in the QIP Completion Instructions.

## Strengths

Anthem demonstrated a strong application of the Design and Implementation stages. For the *Improving HEDIS Postpartum Care Rates* QIP, Alameda and Contra Costa counties achieved statistically significant and sustained improvement at Remeasurement 2.

## Opportunities for Improvement

Anthem has the opportunity to ensure all required documentation is included on the QIP Summary Form prior to submitting the QIP for validation. Although the study indicator for the *Improving HEDIS Postpartum Care Rates* in Alameda and Contra Costa counties achieved statistically significant and sustained improvement over baseline, the rates for the indicator in both counties are still below the DHCS-established MPL for this measure. Additionally, the rates for the indicator in all counties included in the QIP, except San Francisco, continue to be below the MPL. The MCP has the opportunity to conduct new, county-specific barrier analyses and determine if existing interventions need to be discontinued or modified or if new interventions need to be implemented to better address the priority barriers.

## Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Anthem's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

## Findings

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

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

CAHPS Global Rating Measures:

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

CAHPS Composite Measures:

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

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

**Table 5.1—CAHPS Measures Domains of Care**

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

## National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

**Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures**

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

Table 5.3 through Table 5.6 present the star ratings for the global ratings and composite measures for Anthem's adult and child Medicaid populations.[15]

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.
[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.
[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

**Table 5.3—Medi-Cal Managed Care Adult County-Level Global Ratings**
**Anthem—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, San Francisco, and Tulare Counties**

| County | Rating of Health Plan | Rating of All Health Care | Rating of Personal Doctor | Rating of Specialist Seen Most Often |
|---|---|---|---|---|
| Alameda | ★+ | ★+ | ★+ | ★+ |
| Contra Costa | ★+ | ★+ | ★★+ | ★+ |
| Fresno | ★+ | ★+ | ★+ | ★+ |
| Kings | ★+ | ★★★+ | ★★★★+ | ★+ |
| Madera | ★★+ | ★+ | ★★★★★+ | ★+ |
| Sacramento | ★+ | ★+ | ★+ | ★★+ |
| Santa Clara | ★+ | ★★★★+ | ★+ | ★★+ |
| San Francisco | ★+ | ★+ | ★★+ | ★+ |
| Tulare | ★ | ★★+ | ★★+ | ★★+ |

*+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.*

**Table 5.4—Medi-Cal Managed Care Child County-Level Global Ratings**
**Anthem—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, San Francisco, and Tulare Counties**

| County | Rating of Health Plan | Rating of All Health Care | Rating of Personal Doctor | Rating of Specialist Seen Most Often |
|---|---|---|---|---|
| Alameda | ★★+ | ★★+ | ★★★★★+ | ★★★+ |
| Contra Costa | ★★★ | ★★★+ | ★★★+ | ★★★★★+ |
| Fresno | ★★ | ★+ | ★★★+ | ★+ |
| Kings | ★+ | ★+ | ★+ | ★★★★+ |
| Madera | ★★★★ | ★★+ | ★★+ | ★★★★★+ |
| Sacramento | ★ | ★+ | ★+ | ★+ |
| Santa Clara | ★ | ★+ | ★ | ★★★★★+ |
| San Francisco | ★+ | ★★★★★+ | ★★★★+ | ★★★★★+ |
| Tulare | ★★★ | ★+ | ★★+ | ★★★★★+ |

*+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.*

**Table 5.5—Medi-Cal Managed Care Adult County-Level Composite Measures**
**Anthem—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, San Francisco, and Tulare Counties**

| County | Getting Needed Care | Getting Care Quickly | How Well Doctors Communicate | Customer Service |
|---|---|---|---|---|
| Alameda | ★+ | ★+ | ★+ | ★+ |
| Contra Costa | ★★+ | ★+ | ★★★+ | ★+ |
| Fresno | ★+ | ★★+ | ★+ | ★+ |
| Kings | ★★+ | ★★★★+ | ★★★★★+ | ★★+ |
| Madera | ★★+ | ★+ | ★★★★★+ | ★★★★+ |
| Sacramento | ★+ | ★+ | ★+ | ★+ |
| Santa Clara | ★★+ | ★+ | ★★★+ | ★+ |
| San Francisco | ★+ | ★+ | ★★★+ | ★+ |
| Tulare | ★+ | ★+ | ★★+ | ★+ |

*+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.*

**Table 5.6—Medi-Cal Managed Care Child County-Level Composite Measures**
**Anthem—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, San Francisco, and Tulare Counties**

| County | Getting Needed Care | Getting Care Quickly | How Well Doctors Communicate | Customer Service |
|---|---|---|---|---|
| Alameda | ★+ | ★+ | ★+ | ★★★+ |
| Contra Costa | ★★★★+ | ★★★+ | ★★★+ | ★★★★★+ |
| Fresno | ★★+ | ★★+ | ★+ | ★★★+ |
| Kings | ★+ | ★+ | ★+ | ★+ |
| Madera | ★★+ | ★+ | ★+ | ★+ |
| Sacramento | ★+ | ★+ | ★+ | ★+ |
| Santa Clara | ★+ | ★+ | ★+ | ★+ |
| San Francisco | ★★+ | ★+ | ★★+ | ★+ |
| Tulare | ★+ | ★+ | ★+ | ★★★★★+ |

*+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.*

## Strengths

Overall, Kings County received the highest ratings on the adult measures, receiving an *Excellent* rating on one measure, *Very Good* ratings on two measures, and a *Good* rating on one measure. Overall, Contra Costa County received the highest ratings on the child measures, receiving *Excellent* ratings on two child measures, a *Very Good* rating on one child measure, and *Good* ratings on five child measures. For the adult measures, the *How Well Doctors Communicate* measure received the best ratings, with two counties receiving *Excellent* ratings and three counties receiving *Good* ratings. For the child measures, the *Rating of Specialist Seen Most Often* measure received the best ratings, with five counties receiving *Excellent* ratings, one county receiving a *Very Good* rating, and one county receiving a *Good* rating. Please note that the MCP had fewer than 100 respondents for most of the measures across all counties, so caution should be exercised when evaluating these results.

Anthem improved its ratings in Alameda County on the following measures from 2010 to 2013:

- *Rating of All Health Care*—child population
- *Rating of Personal Doctor*—child population
- *Rating of Specialist Seen Most Often*—child population
- *Customer Service*—child population

Anthem improved its ratings in Contra Costa County on the following measures from 2010 to 2013:

- *Rating of Health Plan*—child population
- *Rating of Personal Doctor*—adult population
- *Getting Needed Care*—adult and child populations
- *Getting Care Quickly*—child population
- *How Well Doctors Communicate*—adult and child populations
- *Customer Service*—child population

Anthem improved its ratings in Fresno County on the following measures from 2010 to 2013:

- *Rating of Health Plan*—child population
- *Rating of Personal Doctor*—child population
- *Getting Needed Care*—child population
- *Getting Care Quickly*—adult and child populations
- *Customer Service*—child population

Anthem improved its ratings in Sacramento County on the following measures from 2010 to 2013:

- *Rating of Specialist Seen Most Often*—adult population

Anthem improved its ratings in Santa Clara County on the following measures from 2010 to 2013:

- *Rating of All Health Care*—adult population
- *Rating of Specialist Seen Most Often*—child population
- *Getting Needed Care*—adult population
- *How Well Doctors Communicate*—adult population

Anthem improved its ratings in San Francisco County on the following measures from 2010 to 2013:

- *Rating of All Health Care*—child population
- *Rating of Personal Doctor*—adult and child populations
- *Rating of Specialist Seen Most Often*—child population
- *Getting Needed Care*—child population
- *How Well Doctors Communicate*—adult and child populations

Anthem improved its ratings in Tulare County on the following measures from 2010 to 2013:

- *Rating of All Health Care*—adult population
- *Rating of Specialist Seen Most Often*—adult and child populations
- *How Well Doctors Communicate*—adult population
- *Customer Service*—child population

Kings and Madera counties were not surveyed in 2010.

## Opportunities for Improvement

Anthem's CAHPS results showed below-average performance for the majority of the child and adult global ratings and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as Anthem's highest priorities: *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 Anthem CAHPS MCP-Specific Report.* Areas for improvement spanned the quality, access, and timeliness domains of care.

## Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

## Methodology

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

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[16] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

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

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

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

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

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

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Anthem's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

## Encounter Data Validation Findings

### *Review of Encounter Systems and Processes*

The information provided in Anthem's Roadmap and supplemental questionnaire demonstrate that the MCP has sound procedures in place for the creation, validation, correction, and ongoing monitoring of encounter data. Anthem reported that less than 0.5 percent of claims/encounters were rejected by DHCS for all encounter types, as evidenced by the data and supported by stable claims processing and oversight methods.

### *Record Completeness*

Overall, Anthem had very low record omission and record surplus rates, indicating relatively complete data when comparing DHCS's data and the encounter data extracted from Anthem's data system for this study. Anthem performed better than the respective statewide rates by at least 4 percentage points for all claim types. The Pharmacy records omitted from DHCS's data were mainly from July 2010 and December 2010 (based on dates of service). Similarly, the Pharmacy records omitted from the MCP's data were mainly from August 2010 (based on dates of service). At the county level, the record omission and record surplus rates were fairly consistent. The only notable county variation was that Sacramento County had the highest record omission rates due to duplicate records with a submission date of January 5, 2011 in the MCP's data. Sacramento County was the only county with surplus records.

### Data Element Completeness

Anthem had almost perfect data element completeness results, with element omission and element surplus rates of 0.0 percent for all key data elements in the Medical/Outpatient, Hospital/Inpatient, and Pharmacy encounters. All key data elements met or exceeded the respective statewide rates.

### Data Element Accuracy

Anthem had very high data element accuracy with complete accuracy (100.0 percent) for the majority of the key data elements. Due to a truncation of provider numbers to a length of 10 characters in the DHCS data, the *Billing/Reporting Provider Number* and the *Rendering Provider Number* for the Medical/Outpatient encounters and the *Referring/Prescribing/Admitting Provider Number* for the Medical/Outpatient and Hospital/Inpatient encounters had element accuracy rates between 95.9 percent and 99.7 percent. However, all of the key data element accuracy rates met or exceeded the respective statewide rates across the three claim types. At the county level, the data element accuracy rates were generally consistent. All three claim types had high all-element accuracy rates (greater than 95 percent) that exceeded the respective statewide rates by at least 20 percentage points.

## Recommendations

Based on its review, HSAG recommends the following:

- For DHCS's data and the data Anthem submitted to HSAG, there were no LTC records. However, in Anthem's response to HSAG's preliminary file review results, Anthem indicated that its LTC records were submitted with the Hospital/Inpatient records and Anthem was in the process of implementing stand-alone LTC files for the data submission to DHCS for all counties. Anthem should continue to improve LTC data submission processes and work with DHCS to ensure that the LTC records can be separated from the Hospital/Inpatient records in the DHCS data warehouse.
- Although the record omission and record surplus rates for the Pharmacy claim type were better than the respective statewide rates, there is room for improvement. Anthem should investigate why record omission and record surplus generally originated during certain months or in certain counties. Note that DHCS indicates that its staff worked with Anthem in early 2013 to obtain previously omitted Pharmacy records with July 2010 dates of service.
- For the data elements *Billing/Reporting Provider Number*, *Rendering Provider Number*, and *Referring/Prescribing/Admitting Provider Number,* the field length is 12 characters based on the Encounter Data Element Dictionary. However, these data elements were saved as a 10-character field in the DHCS data warehouse. Although Anthem's accuracy rates for these three data elements exceeded 95 percent, Anthem should try to submit the providers' 10-digit National Provider Identifier (NPI) whenever possible to avoid truncation.

## Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each MCP in the three domains of care—quality, access, and timeliness. A numerical score is calculated for each domain of care for performance measure rates, CAHPS survey measure ratings, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores, CAHPS survey measure ratings scores, and QIP performance scores, is then calculated for each domain of care and converted to a rating of above average, average, or below average. In addition to the performance score derived from performance measures, CAHPS survey measures, and QIPs, HSAG uses results from the MCPs' medical performance and Medi-Cal Managed Care Division reviews and assessment of the accuracy and completeness of encounter data to determine overall performance within each domain of care, as applicable. A more detailed description of HSAG's scoring process is included in Appendix A.

### *Quality*

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[17]

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

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

of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

HSAG reviewed Anthem's quality improvement program description, which includes descriptions of the processes the MCP uses to ensure quality care is provided to its MCMC members.

Overall, Anthem performed below average on measures falling into the quality domain of care. Across all counties, the rates for 12 quality measures were above the HPLs; however, the MCP had 95 quality measures with rates below the MPLs. Across all counties, 20 quality measures had rates that improved significantly from 2012 to 2013, and 26 quality measures had rates that were significantly worse in 2013 when compared to 2012.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care. For all counties except Sacramento County, the SPD rates for most quality measures were similar to the non-SPD rates. Sacramento County had eight quality measures with SPD rates that were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of this population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care. Additionally, Sacramento County's SPD rate for the *All-Cause Readmissions* measure, which falls into the quality domain of care, was significantly higher than the non-SPD rate, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population. The SPD rates for the *All-Cause Readmissions* measure in Alameda, Fresno, Madera, San Joaquin, Stanislaus, and Tulare counties were also significantly higher than the non-SPD rates.

All CAHPS measures fall into the quality domain of care. Across all counties, most of the adult and child measures had a *Fair* or *Poor* rating, and the MCP had fewer than 100 respondents for most measures across all counties, making it difficult to accurately assess members' satisfaction with the quality of care being provided by the MCP.

All three of the MCP's QIPs fall into the quality domain of care. The *All-Cause Readmissions* and *Improving Diabetes Management* QIPs did not progress to the Outcomes stage, so HSAG was not able to assess these QIPs' success at improving the quality of care delivered to the MCP's MCMC members. The *Improving HEDIS Postpartum Care Rates* QIP progressed to the Outcomes stage. Although the study indicators in Contra Costa and Alameda counties achieved statistically significant and sustained improvement at Remeasurement 2, the rates for these indicators remained below the MPLs for the Remeasurement 2 time period (January 1, 2011, through December 31, 2011). Additionally, although the study indicator in San Francisco County has not yet achieved statistically significant improvement over baseline, the rate for this indicator was above the MPL in this county for the Remeasurement 2 time period.

Overall, Anthem showed below-average performance related to the quality domain of care.

### Access

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

HSAG reviewed the quality improvement documents Anthem submitted as part of the process for producing this report and found that the MCP has processes in place to ensure members' access to needed health care services.

Overall, Anthem performed below average on measures falling into the access domain of care. Across all counties, the rates for no access measures were above the HPLs, and the MCP had 87 access measures with rates below the MPLs. Across all counties, 13 access measures had rates that improved significantly from 2012 to 2013, and 25 access measures had rates that were significantly worse in 2013 when compared to 2012.

Nine of the performance measures stratified for the SPD population fall into the access domain of care. For all counties, the SPD rates for most access measures were similar to the non-SPD rates. The *All-Cause Readmissions* measure falls into the access domain of care. As indicated above, the SPD rate for this measure was significantly higher than the non-SPD rate in seven of the MCP's counties, meaning that the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

The *Getting Needed Care* CAHPS measure falls into the access domain of care. Across all counties, all of the adult and child measures except the child measure in Contra Costa County had *Fair* or *Poor* ratings. The child measure in Contra Costa County received a *Very Good* rating. The MCP had fewer than 100 respondents for this measure in all counties, making it difficult to accurately assess members' satisfaction with their access to needed health care services.

All three of the MCP's QIPs fall into the access domain of care. Since the *All-Cause Readmissions* and *Improving Diabetes Management* QIPs did not progress to the Outcomes stage, HSAG was not able to assess these QIPs' success at improving access to needed services. As indicated above, the *Improving HEDIS Postpartum Care Rates* QIP progressed to the Outcomes stage. Although the study indicators in Contra Costa and Alameda counties achieved statistically significant and sustained improvement at Remeasurement 2, the rates for these indicators remained below the MPLs for the Remeasurement 2 time period (January 1, 2011, through December 31, 2011). Additionally, although the study indicator in San Francisco County has not yet achieved statistically significant improvement over baseline, the rate for this indicator was above the MPL in this county for the Remeasurement 2 time period.

Overall, Anthem showed below-average performance related to the access domain of care.

### Timeliness

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

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

Anthem's quality improvement program description includes descriptions of activities and processes related to member rights, grievances, continuity and coordination of care, and utilization management, which all impact the timeliness of care provided to members.

Overall, Anthem performed below average on measures falling into the timeliness domain of care. Across all counties, the rates for no timeliness measures were above the HPLs, and the MCP had 24 timeliness measures with rates below the MPLs. Across all counties, 8 timeliness measures had rates that improved significantly from 2012 to 2013, and 5 timeliness measures had rates that were significantly worse in 2013 when compared to 2012.

The *Getting Care Quickly* CAHPS measure falls into the timeliness domain of care. Across all counties, all of the adult and child measures except the adult measure in Kings County and child measure in Contra Costa County had *Fair* or *Poor* ratings. The adult measure in Kings County

received a *Very Good* rating, and the child measure in Contra Costa County received a *Good* rating. The MCP had fewer than 100 respondents for this measure in all counties, making it difficult to accurately assess members' satisfaction with the timeliness of health care services received by the MCP.

Overall, Anthem showed below-average performance related to the timeliness domain of care.

## Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-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, timeliness, and accessibility of care, HSAG recommends the following to the MCP:

- Continue to work closely with DHCS on implementation and monitoring of the CAP, including conducting ongoing assessment of progress and making changes when indicated.
- Engage in the following efforts to improve performance on required performance measures:
  - For measures where improvement was made from the prior year, assess the factors contributing to the success and duplicate the efforts, as appropriate, across counties.
  - For measures where improvement continues to decline, assess the barriers to improving performance, prioritize the barriers, and identify rapid cycle improvement strategies that will target the barriers.
  - Implement at least quarterly evaluation of progress on performance measure goals and modify, eliminate, or add improvement strategies based on evaluation results.
  - Continue to work with DHCS and the EQRO to identify effective ways to approach improvement efforts, including using data to drive the barrier analysis process, identifying improvement strategies designed to make the greatest impact, and ensuring ongoing evaluation of improvement strategies.
- Engage in the following efforts to improve performance on QIPs:
  - Reference the QIP Completion Instructions to ensure all required documentation is included in the QIP Summary Form.
  - Conduct new county-specific barrier analyses and, based on the evaluation results, determine if existing interventions need to be discontinued or modified or if new interventions need to be implemented to better address the priority barriers.

- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly* priority areas.
- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

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

## Quality, Access, and Timeliness Scoring Process

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

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

## Performance Measure Rates

*(Refer to Tables 3.2 through 3.12)*

### *Quality Domain*

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:

   If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.

   If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.

[18] The CMS protocols specify that the EQRO must include an assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

### *Access and Timeliness Domains*

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:

   If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.

   If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

## CAHPS Survey Measures

*(Refer to Tables 5.3 through 5.6)*

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

### *Quality Domain*

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

### Access Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

### Timeliness Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

## Quality Improvement Projects (QIPs)

***Validation*** *(Table 4.2)*: For each QIP submission and subsequent resubmission(s), if applicable.

1. **Above Average** is not applicable.
2. **Average** = *Met* validation status.
3. **Below Average** = *Partially Met* or *Not Met* validation status.

***Outcomes*** *(Table 4.4)*: Activity IX, Element 4—Real Improvement

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Not all study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

***Sustained Improvement*** *(Table 4.4)*: Activity X—Achieved Sustained Improvement

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **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.

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

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 and Medi-Cal Managed Care Division reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures, CAHPS measures, and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the encounter data validation (EDV) study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

# *Appendix B.* MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

*for* Anthem Blue Cross Partnership Plan

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with Anthem's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

**Table B.1—Anthem's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report**

| 2011–12 External Quality Review Recommendation | Anthem's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation |
|---|---|
| 1. 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. | Anthem Blue Cross Partnership Plan monitors ongoing activities of the health plan and makes every effort to address areas of deficiency in a timely manner. The methods used to correct these deficiencies may vary depending on the nature of the deficiency. The methods may include but are not limited to:<br>• Timely implementation of any process changes necessitated by statute, regulation, or regulatory agency action.<br>• Mailing of Member Notices or Benefit Change Letters to inform members when there is a substantive change to how their plan works or if benefits are added or deleted from the benefit package. |
| 2. Continue to work closely with DHCS on implementation and monitoring of the CAP, including conducting ongoing assessment of progress and making changes when indicated. | A HEDIS CAP was submitted July 7, 2011, by Anthem Blue Cross. Quarterly updates were submitted on January 31, 2012, April 30, 2012, July 31, 2012, and October 31, 2012. Anthem Blue Cross submitted a revised template per DHCS request in January 2013 and is awaiting clarification on reporting requirements and timelines going forward. |
| 3. Work to capture the rendering provider type on all service data and consider making vendor contract changes to reflect the requirements moving forward. | The following enhancements are currently in cue with Anthem Blue Cross' IT department to update the extraction, transformation, and loading (ETL) logic for the following items:<br>Provider Number (PROV_NBR) Modifications<br>• Modify logic to capture the Source Rendering Provider national provider identifier (NPI) where it exists rather than utilizing the EDWard Provider ID for markets where there is not a 1:1 relationship between the EDWard Provider ID and Address |

| 2011–12 External Quality Review Recommendation | Anthem's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation |
|---|---|
| | ○ Streamlines the chase process (roll up chases to the NPI number rather than multiple provider identifiers for the same provider; roll up chases to the same address rather than multiple address locations based on the various WellPoint provider data sources (e.g., EPDS, WMS, NMS, CPF, AMISYS, ACES, FACETS)<br>○ Minimizes the incidence of chases assigned to "default" providers and/or "unknown" providers for NASCO and ITS claims<br>○ Assists with provider research (you can Google the NPI number; WellPoint Provider IDs are meaningless to support staff)<br>CLAIM Specialty<br>• Modifying logic to capture specialty information submitted on the claim for rendering provider<br>○ Eliminates manual workaround employed to improve administrative rates due to having inaccurate or missing provider specialty<br>○ Assists with increasing administrative hits for specialty-driven measures (Comprehensive Diabetes Care eye exams, Glaucoma Screening in Older Adults, Well Visits, etc.)<br>○ Improves the accuracy of identifying the most likely provider to chase<br><br>PROVIDER_LOCATION and LOCATION<br>• Modify logic to improve the address and telephone information specific to a provider<br>○ Improves accuracy and completeness of provider demographic data impacting chases |
| 4. Work with HSAG when developing additional supplemental sources of data to ensure the data sources meet NCQA reporting requirements. | At this time, there are no new/additional supplemental data sources planned for HEDIS 2014, but Anthem Blue Cross is open to discussing possible supplemental sources of data with HSAG. |
| 5. 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. | Quarterly updates submitted on January 31, 2012, April 30, 2012, July 31, 2012, and October 31, 2012, provided an assessment of factors that contributed to the success of measures during this time period.<br><br>The following trends were observed and highlighted in discussions at monthly workstream meetings. Field representatives and intervention specialists identified best practices. Plans were considered for continuance of these best practices or implementation in counties that did not perform as well.<br>The following are examples of the improved metrics by county:<br>WCC- BMI: Sacramento, Tulare |

| 2011–12 External Quality Review Recommendation | Anthem's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation |
|---|---|
| | WCC- Nutrition: Sacramento, Alameda, Tulare<br>WCC- Physical Activity: Sacramento, Tulare<br>Prenatal: Sacramento<br>AWC: Sacramento, San Joaquin, Contra Costa, Tulare, Stanislaus, Santa Clara, San Francisco, Alameda<br>CIS Combo 3: Stanislaus<br>CDC-EYE: Stanislaus, Alameda<br>W34: Alameda, Santa Clara |
| 6. 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. | Quarterly updates submitted on January 31, 2012, April 30, 2012, July 31, 2012, and October 31, 2012, provided an assessment of factors that contributed to the barriers that contributed to the decline of measures during this time period. Strategies were identified and implemented in each Anthem county. |
| 7. 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. | Anthem Blue Cross conducts a barrier analysis process for each measure with stakeholder representatives (quality, intervention design, field staff, and medical director). Barriers are prioritized by strength of challenge based on rates and gap in care data. When such quantitative data are not available, we use anecdotal data and brainstorming methods for collecting analytical evidence. For drilling down complex barriers, we have made use of fishbone diagrams to visually depict the contributors from many sources. |
| 8. 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. | Anthem Blue Cross plans interventions to address high-priority barriers. The method to evaluate effectiveness of interventions includes periodic monitoring of activity statistics on a quarterly basis. On an annual basis, progress is evaluated based on the HEDIS results. |