Performance Evaluation Report

Anthem Blue Cross Partnership Plan

July 1, 2013–June 30, 2014

Managed Care Quality and Monitoring 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 7.7 million beneficiaries (as of June 2014)[1] in the State of California through a combination of contracted full-scope and specialty managed care health 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 Technical Report, July 1, 2013–June 30, 2014*. 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 survey and

[1] *Medi-Cal Managed Care Enrollment Report—June 2014*. 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.

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

- MCP-specific evaluation reports (July 1, 2013–June 30, 2014). 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, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Health Plan Overview

Anthem, formerly Blue Cross of California prior to April 1, 2008, operated in nine counties during the July 1, 2013, through June 30, 2014, review period for this report and in 19 counties from November 1, 2013, through June 30, 2014. Anthem, a full-scope MCP, delivers care to members under the Two-Plan Model (TPM) in eight counties, the Regional model in 18 counties, the Geographic Managed Care (GMC) model in one county, and the San Benito model in one county.

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. Anthem expanded into Kings and Madera counties in March 2011 and continued providing services in Fresno County under a new contract covering Fresno, Kings, and Madera counties. As part of the expansion authority under Section 1115 of the Social Security Act, MCMC expanded into several rural eastern counties of California in 2013. Under the expansion, Anthem contracted with DHCS to provide MCMC services in Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba, and San Benito counties beginning November 1, 2013.

Anthem delivers services to its MCMC members as a "Local Initiative" (LI) and "commercial plan" (CP) MCP under the TPM. In TPM counties, MCMC beneficiaries may choose between two MCPs; typically, one MCP is an LI and the other a CP. DHCS contracts with both plans. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. Table 1.1 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.

Table 1.1—Anthem Counties Under the Two-Plan Model

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 delivers services to its MCMC members under the GMC model in Sacramento County. The other MCPs operating in Sacramento County are Health Net Community Solutions, Inc.; Kaiser Permanente North; and Molina Healthcare of California Partner Plan, Inc. In the GMC model, DHCS allows MCMC beneficiaries to select from several commercial MCPs within a specified geographic area. The GMC model currently operates in San Diego and Sacramento counties.

Anthem delivers services to its MCMC members under the Regional model in Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba counties. The other MCPs operating under the Regional model are California Health & Wellness and Kaiser Permanente North. California Health & Wellness operates in all of 18 counties, and Kaiser Permanente North operates in Amador, El Dorado, and Placer counties. In Regional model counties, DHCS contracts with CPs to provide MCMC services.

Anthem delivers services to its MCMC members under the San Benito model in San Benito County. In the San Benito model, there is one CP and DHCS contracts with the plan. In a San Benito model county, MCMC beneficiaries can choose the MCP or regular (fee-for-service) Medi-Cal.

Table 1.2 shows the number of MCMC members for Anthem for each county and the MCP's total number of members as of June 30, 2014.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Table 1.2—Anthem Enrollment as of June 30, 2014

County	Enrollment as of June 30, 2014
Alameda	48,436
Alpine	117
Amador	3,461
Butte	19,227
Calaveras	2,481
Colusa	3,008
Contra Costa	19,478
El Dorado	6,776
Fresno	87,476
Glenn	3,007
Inyo	1,521
Kings	15,936
Madera	16,027
Mariposa	1,845
Mono	940
Nevada	10,359
Placer	19,986
Plumas	1,400
Sacramento	124,254
San Benito	6,556
San Francisco	18,647
Santa Clara	49,956
Sierra	259
Sutter	12,721
Tehama	6,776
Tulare	84,642
Tuolumne	3,335
Yuba	9,406
Total	**578,033**

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 review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, 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 medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. 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 evaluate 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's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

Medical Audits and SPD Medical Surveys

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were

conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

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

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

DHCS conducted no audits or reviews with Anthem during the review period for this report. The most recent Member Rights & Program Integrity Unit review with Anthem was conducted in May 2009, and the most recent DHCS medical performance review was conducted in September 2009. HSAG summarized the findings from these reviews in Anthem's previous MCP-specific evaluation reports.

Strengths

Since DHCS conducted no reviews with Anthem during the reporting period, HSAG identified no areas of strength for Anthem related to compliance reviews.

Opportunities for Improvement

Since DHCS conducted no new reviews with Anthem during the reporting period, HSAG has no recommendations for Anthem related to compliance reviews.

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, 2013–June 30, 2014*, 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.[4] 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.

[4] 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 2014 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[5] 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 32. 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™[6] of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 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.

To report HEDIS measure rates, MCPs must first have members meet continuous enrollment requirements for each measure being reported, which typically means members need to be enrolled in the MCP for 11 of 12 months during the measurement year. No Anthem Medi-Cal members in Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba, or San Benito counties had continuous enrollment during 2013. Consequently, HSAG did not include these counties in the 2014 NCQA HEDIS Compliance Audit conducted with Anthem, and no data for these counties are included in this report. HSAG will include the expansion counties in the 2015 NCQA HEDIS Compliance Audit process, and rates for the counties will be included in Anthem's 2014–15 MCP-specific evaluation report.

Performance Measure Validation Findings

The *HEDIS 2014 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, and no issues of concern were identified. A brief summary of the findings is included below.

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

- Anthem provided sufficient, ongoing oversight of its vendor's performance.
- Anthem experienced two major membership changes during the reporting period:
  - Anthem transitioned its Healthy Families Program population into MCMC.
  - Anthem terminated its contracts with DHCS for two counties (San Joaquin and Stanislaus).

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 through Table 3.9 present a summary of Anthem's performance measure results for 2011–14. Note that data may not be available for all four years.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 through Table 3.9 show the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

DHCS based the MPLs and HPLs on the 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.

The reader should note the following regarding Table 3.1 through Table 3.9:

- The *All-Cause Readmissions* measure is a non-HEDIS measure used for the ACR collaborative QIP; therefore, no MPL or HPL is established for this measure.
- For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- The *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures. No MPL or HPL is established for a utilization measure. Additionally, HSAG did not compare performance for these measures.
- Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for 2014:
  - All four *Children and Adolescents' Access to Primary Care* measures.

- *Cervical Cancer Screening*. Note: MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008; however, due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014. Consequently, HSAG did not include or make comparisons to previous years' rates in this report.
- *Comprehensive Diabetes Care—LDL-C Control*. (This measure is being eliminated for HEDIS 2015.)
- *Comprehensive Diabetes Care—LDL-C Screening*. (This measure is being eliminated for HEDIS 2015.)

Table 3.1—Performance Measure Results
Anthem—Alameda County

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

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Comprehensive Diabetes Care—LDL-C Screening	Q,A	**68.37%**	**66.91%**	**55.83%**	**61.37%**	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	**68.86%**	**68.86%**	**71.36%**	**73.95%**	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	**53.53%**	**60.58%**	**63.35%**	**67.55%**	↔
Controlling High Blood Pressure	Q	—	—	**30.66%**	**34.15%**	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	64.96%	73.16%	73.04%	↔
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	**42.61%**	**44.30%**	↔
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	**20.87%**	**21.94%**	↔
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**51.09%**	**50.61%**	**36.74%**	**50.23%**	↑
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**65.94%**	**72.99%**	**75.18%**	**73.95%**	↔
Use of Imaging Studies for Low Back Pain	Q	86.88%	91.46%	90.20%	88.04%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	46.96%	44.04%	62.29%	46.17%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	55.23%	62.04%	61.07%	**47.33%**	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	28.47%	31.14%	37.47%	40.84%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	**62.04%**	73.71%	**57.32%**	**65.51%**	↑

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.2—Performance Measure Results
Anthem—Contra Costa County

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

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**43.55%**	**48.15%**	**44.64%**	**44.26%**	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**69.35%**	**76.30%**	**79.46%**	**72.95%**	↔
Use of Imaging Studies for Low Back Pain	Q	85.92%	92.59%	81.48%	S	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	49.15%	42.58%	57.66%	50.00%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	52.80%	53.77%	52.31%	55.09%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	35.28%	**25.55%**	36.74%	47.92%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	**63.26%**	67.45%	**63.93%**	75.83%	↑

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

**Table 3.3—Performance Measure Results
Anthem—Fresno County**

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

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**50.85%**	—	**54.74%**	**52.90%**	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**70.56%**	—	**79.56%**	**74.94%**	↔
Use of Imaging Studies for Low Back Pain	Q	80.58%	—	84.06%	82.85%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	47.20%	—	58.88%	54.29%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	53.04%	—	63.02%	59.86%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	36.25%	—	46.23%	49.65%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.72%	—	67.88%	79.63%	↑

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.4—Performance Measure Results
Anthem—Kings County

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

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	**54.37%**	**45.70%**	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	86.11%	80.08%	↔
Use of Imaging Studies for Low Back Pain	Q	—	—	76.03%	84.30%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	46.47%	40.74%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	44.04%	**43.29%**	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	**31.39%**	38.66%	↑
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	**57.66%**	**65.05%**	↑

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.5—Performance Measure Results
Anthem—Madera County

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

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	—	—	**51.57%**	59.89%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	—	—	**76.10%**	**77.47%**	↔
Use of Imaging Studies for Low Back Pain	Q	—	—	**70.10%**	83.54%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	—	—	77.62%	56.94%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	—	—	70.07%	61.81%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	—	—	48.66%	52.55%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	—	—	80.29%	86.81%	↑

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.6—Performance Measure Results
Anthem—Sacramento County

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

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**49.88%**	**54.26%**	**47.92%**	**49.88%**	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	**70.32%**	**76.89%**	**78.73%**	**72.39%**	↓
Use of Imaging Studies for Low Back Pain	Q	83.69%	84.94%	84.34%	83.20%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	49.88%	63.02%	65.45%	61.11%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	59.61%	71.29%	69.34%	63.43%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	27.74%	39.42%	44.53%	47.45%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.72%	**64.33%**	67.37%	70.83%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.7—Performance Measure Results
Anthem—San Francisco County

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

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	**55.50%**	64.02%	64.85%	**56.55%**	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	87.96%	85.71%	88.48%	**77.38%**	↓
Use of Imaging Studies for Low Back Pain	Q	85.37%	80.39%	86.73%	89.11%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	53.53%	73.24%	60.06%	78.47%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	70.80%	79.32%	72.99%	75.00%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	56.20%	71.78%	65.52%	68.06%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	76.40%	80.00%	79.26%	80.55%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.8—Performance Measure Results
Anthem—Santa Clara County

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

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	65.69%	60.64%	**56.20%**	60.65%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	83.45%	**79.52%**	**76.71%**	80.09%	↔
Use of Imaging Studies for Low Back Pain	Q	83.92%	82.43%	83.67%	80.35%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	65.69%	53.28%	55.23%	48.15%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	63.50%	70.56%	65.94%	**46.99%**	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	35.52%	38.44%	50.36%	**34.49%**	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	70.07%	76.72%	76.72%	74.45%	↔

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.9—Performance Measure Results
Anthem—Tulare County

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

Measure[1]	Domain of Care[2]	2011[3]	2012[4]	2013[5]	2014[6]	2013–14 Rate Difference[7]
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	63.99%	**53.13%**	**55.96%**	58.24%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	82.73%	83.07%	**76.16%**	82.37%	↑
Use of Imaging Studies for Low Back Pain	Q	79.56%	80.85%	81.07%	85.90%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	32.60%	83.94%	81.51%	65.28%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	48.91%	68.13%	64.23%	57.18%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	30.17%	50.36%	47.93%	47.92%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	73.24%	71.95%	**64.91%**	71.93%	↑

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.
[4] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[5] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[6] 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[7] Performance comparisons are based on the Chi-Square test of statistical significance with a p value of <0.05.
‡ This is a utilization measure, which is not assigned a domain of care.
-- Indicates the rate is not available.
↓ = Statistically significant decline.
↔ = No statistically significant change.
↑ = Statistically significant improvement.
▲▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.
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),[7] 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.

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

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in 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 Table 3.10 through Table 3.27, which present a summary of Anthem's 2014 SPD measure results. Table 3.10 through Table 3.18 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[8] and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.19 through Table 3.27 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—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*

[8] 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 Table 3.10 through Table 3.18.

Table 3.10—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Alameda County

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

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different 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.

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

Table 3.11—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Contra Costa County

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

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different 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.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 3.12—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Fresno County

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

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different 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.

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

Table 3.13—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Kings County

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

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different 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.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 3.14—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Madera County

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

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different 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.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 3.15—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Sacramento County

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

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different 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.

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

Table 3.16—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—San Francisco County

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

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different 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.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table 3.17—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Santa Clara County

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

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different 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.

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

Table 3.18—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for Anthem—Tulare County

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

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

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different 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.

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

**Table 3.19—2014 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
187.84	53.18	294.17	115.98

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

**Table 3.20—2014 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
225.26	56.15	284.86	97.01

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

**Table 3.21—2014 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
219.48	45.59	367.46	74.31

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

**Table 3.22—2014 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
291.39	61.93	563.40	119.47

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

Table 3.23—2014 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
272.13	54.40	509.81	98.73

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

Table 3.24—2014 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
191.26	48.19	356.44	82.77

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

Table 3.25—2014 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
245.67	35.87	373.20	95.72

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

Table 3.26—2014 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
232.83	41.56	374.95	74.19

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

Table 3.27—2014 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
305.19	39.20	561.54	83.89

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

Performance Measure Result Findings

Across all counties, 12 rates were above the HPLs. The rate was above the HPL for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure for the fourth consecutive year for San Francisco County. The rate was above the HPL for the *Use of Imaging for Low Back Pain* measure for all counties except Santa Clara County, with the rate for Alameda County being above the HPL for the fourth consecutive year and the rate for Sacramento County being above the HPL for the third consecutive year. The rate was above the HPL for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* for the third consecutive year for San Francisco County.

Tulare County showed the most improvement from 2013 to 2014, with 10 rates improving significantly from 2013 to 2014 and the rates for 12 measures moving from below the MPLs in 2013 to above the MPLs in 2014. Alameda County had the most measures with rates below the MPLs (22), and Santa Clara County had the most measures with rates significantly worse in 2014 when compared to 2013 (seven). Across all counties, 19 rates moved from above the MPLs in 2013 to below the MPLs in 2014, and 108 rates were below the MPLs.

Despite Anthem's efforts to improve performance on measures (see Appendix D), the MCP continued to demonstrate difficulty meeting DHCS's minimum performance requirements for many measures, across all counties.

Seniors and Persons with Disabilities Findings

Across all counties, 20 SPD rates were significantly better than the non-SPD rates. Alameda and Sacramento counties each had four measures with significantly better SPD rates; Kings County had three measures with significantly better SPD rates; Contra Costa, Santa Clara, and Tulare counties each had two measures with significantly better SPD rates; and Fresno, Madera, and San Francisco counties each had one measure with significantly better SPD rates. The better SPD rates are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to more monitoring of care.

Across all counties, 16 SPD rates were significantly worse than the non-SPD rates. Concerning measures with significantly worse SPD rates, Alameda, Sacramento, San Francisco, and Santa Clara counties each had three; Tulare County had two; and Fresno and Kings counties each had one. Contra Costa and Madera counties had no measures with significantly worse 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 the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act (PDSA) cycle. DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

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

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

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e.,

immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid-cycle approach (including the Plan-Do-Study-Act cycle) to strengthen these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

Assessment of MCP's Improvement Plans

Based on continued poor performance, DHCS required Anthem to continue its CAP, which was implemented in 2011 and revised in November 2013. Anthem is required to conduct additional QIPs, IPs, and PDSA cycles as part of the CAP. DHCS requires the MCP to report quarterly progress on the QIPs, IPs, and PDSA cycles and meets monthly with Anthem to discuss progress on the CAP goals and next steps. Anthem is required to meet with DHCS leadership quarterly to provide CAP updates and progress. Anthem is required to submit extensive documentation to DHCS related to all CAP requirements, and DHCS and the EQRO provide the MCP with feedback on CAP activities. Despite the comprehensive CAP, Anthem's performance on many measures continued to be below DHCS's minimum requirements, and the MCP will be required to continue the CAP in 2014.

Strengths

During the 2014 HEDIS audit with Anthem, HSAG auditors determined that the MCP followed the appropriate specifications to produce valid performance measure rates.

Although Anthem continued to show many opportunities for improvement, across all counties 12 rates were above the HPLs, and 40 rates were significantly better in 2014 when compared to 2013. Additionally, across all counties, 32 rates moved from below the MPLs in 2013 to above the MPLs in 2014.

Opportunities for Improvement

As has been noted in previous years, Anthem has many opportunities for improvement related to performance measures, despite the MCP's efforts to make improvements (see Appendix D). In instances where rates have improved, Anthem has the opportunity to assess the factors contributing to the improvement and duplicate the improvement strategies, as appropriate, across counties. For measures with rates that continue to decline and for measures with rates below the MPLs, Anthem has the opportunity to reassess the barriers to the MCP improving performance, prioritize the barriers, and identify rapid-cycle improvement strategies to target the prioritized barriers. Additionally, Anthem has the opportunity to continue quarterly evaluation of the MCP's

improvement efforts so that effective strategies can be expanded and ineffective strategies can be modified or eliminated.

Finally, Anthem has the opportunity to continue to work with DHCS and the EQRO to identify priority areas for improvement and strategies that have the best chance of resulting in positive outcomes.

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[9] 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, 2013–June 30, 2014,* 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.

[9] 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 five internal QIPs in progress during the review period of July 1, 2013–June 30, 2014.

Table 4.1 below lists Anthem's QIPs and indicates the county 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, 2013, through June 30, 2014

QIP	Counties	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, Tulare	Clinical	Q, A
Childhood Immunization Status	Sacramento	Clinical	Q, A, T
Improving Diabetes Management (Closed)	Alameda, Contra Costa, Fresno, Kings, Madera	Clinical	Q, A
Improving Diabetes Management (Open)	Alameda, Contra Costa, Fresno, Kings, Sacramento, San Francisco, Tulare	Clinical	Q, A
Improving HEDIS Postpartum Care Rates	Alameda, Contra Costa, Sacramento, San Francisco, San Joaquin,* Santa Clara, Stanislaus,* Tulare	Clinical	Q, A, T
Improving Timeliness of Prenatal and Postpartum Care	Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, Tulare	Clinical	Q, A, T

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

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.

The *Childhood Immunization Status* QIP targeted beneficiaries who will turn 2 years of age during the measurement year. The administration of immunizations has dramatically decreased the

occurrence of many diseases including diphtheria, tetanus, pertussis, and small pox. However, due to either misconceptions about immunizations' side effects or lack of access, the number of children who have not received immunizations has increased. By understanding why children are not receiving life-saving vaccines, Anthem hopes to increase the percentage of children who receive the recommended immunizations.

Both *Improving Diabetes Management* QIPs targeted members with diabetes. The *Improving Diabetes Management* (Closed) QIP focused on improving HbA1c screening and retinal eye exams, while the *Improving Diabetes Management* (Open) QIP focused on improving blood pressure control; HbA1c control (<8.0 percent), poor control (>9.0 percent), and testing; nephropathy; and retinal eye exams. Ongoing management of members with diabetes is critical to preventing complications and ensuring their optimal health.

The *Improving HEDIS Postpartum Care Rates* (Closed) 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 28.8 percent to 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 those mothers.

Anthem's *Improving Timeliness of Prenatal and Postpartum Care* QIP focused on improving the care women receive during and post pregnancy. Maintaining regular prenatal care visits throughout a pregnancy may help in the identification and treatment of any problems that may arise. Providing postpartum care is essential to positive health outcomes.

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, 2013, through June 30, 2014

Name of Project/Study	Counties	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	All counties—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, and Tulare—received the same score.	Annual Submission	81%	100%	*Met*
Internal QIPs					
Childhood Immunization Status	Sacramento	Study Design Submission	88%	71%	*Not Met*
		Study Design Resubmission 1	100%	100%	*Met*
Improving Diabetes Management (Closed)	Alameda and Contra Costa counties received the same score.	Annual Submission	84%	90%	*Partially Met*
		Annual Resubmission 1	96%	90%	*Partially Met*
	Fresno, Kings, and Madera counties received the same score.	Annual Submission	80%	80%	*Partially Met*
		Annual Resubmission 1	96%	90%	*Partially Met*
Improving Diabetes Management (Open)	All counties—Alameda, Contra Costa, Fresno, Kings, Sacramento, San Francisco, and Tulare—received the same score.	Study Design Submission	94%	86%	*Not Met*
		Study Design Resubmission 1	100%	100%	*Met*
Improving HEDIS Postpartum Care Rates (Closed)	Sacramento	Annual Submission	85%	90%	*Partially Met*
	San Francisco	Annual Submission	83%	90%	*Partially Met*
	San Joaquin*	Annual Submission	57%	70%	*Not Met*
	Santa Clara	Annual Submission	86%	90%	*Partially Met*
	Stanislaus*	Annual Submission	57%	70%	*Not Met*
	Tulare	Annual Submission	89%	90%	*Partially Met*

Name of Project/Study	Counties	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Improving Timeliness of Prenatal and Postpartum Care	All counties—Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, and Tulare—received the same score.	Study Design Submission	94%	86%	*Not Met*
		Study Design Resubmission 1	100%	100%	*Met*

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

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

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

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

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

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that Anthem's annual submission of its *All-Cause Readmissions* QIP achieved an overall *Met* validation status for Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, Santa Clara, and Tulare counties, with 81 percent of the evaluation elements and 100 percent of the critical elements receiving a met score. The *Childhood Immunization Status* QIP study design submission for Sacramento County received an overall validation status of *Not Met.* As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on HSAG's validation feedback, Anthem resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score. The *Improving Diabetes Management* (Open) QIP study design submission received an overall validation status of *Not Met* for Alameda, Contra Costa, Fresno, Kings, Sacramento, San Francisco, and Tulare counties. Anthem resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of evaluation elements (critical and noncritical) receiving a met score. Finally, the *Improving Timeliness of Prenatal and Postpartum Care* QIP study design submission achieved an overall validation status of *Not Met* for Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, Santa Clara, and Tulare counties. Anthem resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of evaluation elements (critical and noncritical) receiving a met score.

Anthem's annual submission of the *Improving Diabetes Management* (Closed) QIP received an overall *Partially Met* validation status for all counties, and the annual submission of the *Improving HEDIS Postpartum Care Rates* (Closed) QIP received an overall *Partially Met* validation status for

Sacramento, San Francisco, Santa Clara, and Tulare counties and a *Not Met* validation status for San Joaquin and Stanislaus counties. Due to Anthem's poor performance on multiple measures, DHCS implemented a CAP. Anthem was instructed to close the *Improving Diabetes Management* (Closed) and *Improving HEDIS Postpartum Care Rates* (Closed) QIPs with no further validation and required to initiate two new QIPs—a diabetes QIP and a prenatal and postpartum QIP. Anthem was not required to submit any further documentation regarding the *Improving Diabetes Management* (Closed) or *Improving HEDIS Postpartum Care Rates* (Closed) QIPs.

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 = 57 QIP Submissions, 6 QIP Topics)
July 1, 2013, through June 30, 2014

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	97%	3%	0%
	II: Clearly Defined, Answerable Study Question(s)	98%	2%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	98%	0%	2%
	VI: Accurate/Complete Data Collection	88%	6%	6%
Design Total**		**95%**	**2%**	**2%**
Implementation	VII: Sufficient Data Analysis and Interpretation	77%	0%	23%
	VIII: Appropriate Improvement Strategies	48%	45%	7%
Implementation Total**		**69%**	**14%**	**18%**
Outcomes	IX: Real Improvement Achieved**	38%	0%	63%
	X: Sustained Improvement Achieved	50%	0%	50%
Outcomes Total**		**38%**	**0%**	**62%**

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

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

Please note that the aggregated percentages for Activities I through X in Table 4.3 include the scores from Anthem's *Improving Diabetes Management* (Closed) and *Improving HEDIS Postpartum Care Rates* (Closed) QIPs. HSAG does not provide any details regarding deficiencies noted during the validation process in this report since the MCP was not required to resubmit the QIPs to address the deficiencies and the QIPs were closed.

HSAG validated Activities I through VIII for Anthem's *All-Cause Readmissions* and *Improving Diabetes Management* (Closed) QIP annual submissions; Activities I through VI for the *Childhood Immunization Status, Improving Diabetes Management* (Open), and *Improving Timeliness of Prenatal and Postpartum Care* QIPs' study design submissions; and Activities I through X for the MCP's *Improving HEDIS Postpartum Care Rates* (Closed) QIP annual submission.

Anthem demonstrated a strong application of the Design stage, meeting 95 percent of the requirements for all applicable evaluation elements within the study stage for all six QIPs. For the *All-Cause Readmissions* QIP, the MCP did not fully describe its data collection or data analysis plans, resulting in a lower score for Activity VI. For the *Childhood Immunization Status, Improving Diabetes Management* (Open), and *Improving Timeliness of Prenatal and Postpartum Care* study design submissions, Anthem did not provide the medical record abstraction tool, resulting in a lowered score for Activity VI. Additionally, for the *Childhood Immunization Status* QIP, the MCP did not provide an appropriate study question, resulting in a lower score for Activity II. Anthem corrected these deficiencies in the resubmissions, resulting in the QIPs achieving an overall *Met* validation status. Anthem met all requirements for all applicable evaluation elements within the Design stage for its *Improving HEDIS Postpartum Care Rates* QIP. The remaining deficiencies attributed to this stage were in the MCP's documentation in the *Improving Diabetes Management* (Closed) QIP. As indicated above, since this QIP was closed prior to achieving a *Met* status, HSAG provides no details regarding deficiencies noted during the validation process.

The *All-Cause Readmissions, Improving Diabetes Management* (Closed), and *Improving HEDIS Postpartum Care Rates* (Closed) QIPs progressed to the Implementation stage during the reporting period. Anthem struggled with its application of the Implementation stage for these QIPs, meeting 69 percent of the requirements for all applicable evaluation elements within the study stage. For the *All-Cause Readmissions* QIP, Anthem did not indicate if there were any factors that threatened the internal or external validity of the findings, resulting in a lower score for Activity VII. This was the only deficiency in the *All-Cause Readmissions* QIP submission. The remaining deficiencies attributed to this stage were in the MCP's documentation in the *Improving Diabetes Management* (Closed) and *Improving HEDIS Postpartum Care Rates* (Closed) QIPs; however, since these QIPs were closed prior to achieving a *Met* status, HSAG provides no details regarding deficiencies noted during the validation process.

Only the *Improving HEDIS Postpartum Care Rates* (Closed) QIP progressed to the Outcomes stage during the reporting period. The QIP results for the Outcomes stage varied between counties:

- The study indicator in Tulare County achieved statistically significant improvement over baseline at Remeasurement 1 and sustained the improvement at Remeasurement 3; however, the rate for the indicator declined slightly at Remeasurement 3, resulting in a lower score for Activity IX.
- Although the study indicator for Santa Clara County achieved statistically significant improvement over baseline at Remeasurement 1, the indicator's rate declined at both

Remeasurement 2 and Remeasurement 3. The decline in the indicator's rate and the fact that the indicator did not sustain the statistically significant improvement achieved 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

The *Childhood Immunization Status, Improving Diabetes Management* (Open), and *Improving Timeliness of Prenatal and Postpartum Care* QIPs did not progress to the Implementation or Outcomes stages during the reporting period; therefore, no intervention or outcome information is included in this report.

Although the *Improving Diabetes Management* (Closed) QIP progressed to the Implementation stage during the reporting period, since the QIP was closed prior to achieving a *Met* status, HSAG provides no details regarding interventions for this QIP.

The *All-Cause Readmissions* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP's interventions for the *All-Cause Readmissions* QIP:

- Implemented a formal process to facilitate a safe discharge and/or transition of care for members.
- Provided education and counseling for members and families to enhance active participation in their own care.
- Discharge planners assessed the member's family dynamics prior to discharge to identify potential family or financial issues.

Outcome information for the *All-Cause Readmissions* QIP will be included in Anthem's 2014–15 MCP-specific evaluation report.

Although the *Improving HEDIS Postpartum Care Rates* (Closed) QIP was closed, since the MCP reported outcomes for the QIP, they are included in this report. Table 4.4 summarizes the *Improving HEDIS Postpartum Care Rates* (Closed) 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).

Table 4.4—Quality Improvement Project Outcomes for Anthem—Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties July 1, 2013, through June 30, 2014

QIP #1—Improving HEDIS Postpartum Care Rates					
Study Indicator: Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.					
County	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Remeasurement 3 1/1/12–12/31/12**	**Sustained Improvement¥**
Sacramento	52.1%	49.9%	54.3%	47.9%	‡
San Francisco	57.4%	55.5%	64.0%	64.8%	‡
San Joaquin	48.9%	51.3%	48.2%	***	‡
Santa Clara	55.5%	65.7%*	60.6%	56.5%	No
Stanislaus	54.3%	53.7%	56.7%	***	‡
Tulare	46.5%	64.0%*	53.1%**	56.2%*	Yes

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

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

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

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

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

Improving HEDIS Postpartum Care Rates QIP

For the *Improving HEDIS Postpartum Care Rates* (Closed) 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. Overall, the MCP did not meet the objective for this QIP; however, the indicator for Tulare County exceeded the project's objective and achieved statistically significant and sustained improvement at Remeasurement 3. Although the indicator for Santa Clara County achieved statistically significant improvement at Remeasurement 1, the improvement was not sustained at Remeasurement 2 or Remeasurement 3. Instead, the rate declined by more than 9 percentage points from Remeasurement 1 to Remeasurement 3. No statistically significant improvement was achieved for the indicators in the other counties.

Strengths

Anthem demonstrated an excellent application of the QIP Design stage for all QIPs. Anthem also demonstrated an excellent application of the QIP process for the *All-Cause Readmissions* QIP, by achieving a *Met* validation status for this QIP on the first submission.

For the *Improving HEDIS Postpartum Care Rates* (Closed) QIP, the indicator for Tulare County achieved statistically significant and sustained improvement at Remeasurement 3.

Opportunities for Improvement

In response to HSAG's recommendations in Anthem's 2012–13 MCP-specific evaluation report, Anthem implemented a process to ensure that evaluation elements that received a *Not Met* or *Partially Met* validation status were corrected prior to submission (see Appendix D). Although this process appeared to work for the *All-Cause Readmissions* QIP, the MCP provided incomplete or inaccurate documentation for its other QIPs, demonstrating opportunities for improving its QIP documentation. The MCP should continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

Conducting the EQRO Review

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

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

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

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, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures 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 and QIPs, HSAG uses results from the MCPs' medical audit/SPD medical survey 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 C.

Please note that when a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care.

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.[10]

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

[10] 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.

Anthem's quality improvement program description provides information about the MCP's quality program structure, which supports the provision of quality care to the MCP's members.

The rates were above the HPLs for the following quality performance measures:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* for Contra Costa and San Francisco counties, with the rate for San Francisco County being above the HPL for the fourth consecutive year
- *Use of Imaging Studies for Low Back Pain* for Alameda, Contra Costa, Fresno, Kings, Madera, Sacramento, San Francisco, and Tulare counties, with the rate for Alameda County being above the HPL for the fourth consecutive year and the rate for Sacramento County being above the HPL for the third consecutive year
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total* for San Francisco County for the third consecutive year
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* for Madera County

Across all counties, 29 rates were significantly better in 2014 when compared to 2013 for measures in the quality domain of care. Additionally, 26 rates for quality measures moved from below the MPLs in 2013 to above the MPLs in 2014. While Anthem improved performance on some quality measures, 16 rates for quality measures moved from above the MPLs in 2013 to below the MPLs in 2014, and 88 rates were below the MPLs for measures falling into the quality domain of care.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care. Across all counties, most SPD rates were similar to the non-SPD rates for measures stratified for the SPD population.

All six of Anthem's QIPs fell into the quality domain of care. Only the *Improving HEDIS Postpartum Care Rates* (Closed) QIP progressed to the Outcomes stage. Overall, the QIP was not successful at improving postpartum care rates, which suggests the MCP has opportunities to improve the quality of care provided to women in need of postpartum care.

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 Anthem's quality improvement program description and found that the MCP included descriptions of processes to monitor member access to care. Additionally, Anthem provided the results of the MCP's quality improvement program evaluation, which showed that the MCP did not meet most of its access-related goals.

Only one access measure had a rate above the HPL—*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*—for Madera County.

Across all counties, 28 rates were significantly better in 2014 when compared to 2013 for measures in the access domain of care. Additionally, 21 rates for access measures moved from below the MPLs in 2013 to above the MPLs in 2014. While Anthem improved performance on some access measures, nine rates for access measures moved from above the MPLs in 2013 to below the MPLs in 2014, and 57 rates were below the MPLs for measures falling into the access domain of care.

Nine of the performance measures stratified for the SPD population fall into the access domain of care. Across all counties, most SPD rates were similar to the non-SPD rates for measures stratified for the SPD population.

All six of Anthem's QIPs fell into the access domain of care. Only the *Improving HEDIS Postpartum Care Rates* (Closed) QIP progressed to the Outcomes stage. As indicated above, overall, the QIP was not successful at improving postpartum care rates, which suggests the MCP has opportunities to improve access to care for women in need of postpartum care services.

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 information on the MCP's processes related to grievances, continuity and coordination of care, and utilization management, which all affect the timeliness of care provided to members.

Only one timeliness measure had a rate above the HPL—*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*—for Madera County.

Across all counties, 11 rates were significantly better in 2014 when compared to 2013 for measures in the timeliness domain of care. Additionally, seven rates for timeliness measures moved from below the MPLs in 2013 to above the MPLs in 2014. While Anthem improved performance on some timeliness measures, three rates for timeliness measures moved from above the MPLs in 2013 to below the MPLs in 2014, and 16 rates were below the MPLs for measures falling into the timeliness domain of care.

Three of Anthem's six QIPs fell into the timeliness domain of care; however, only the *Improving HEDIS Postpartum Care Rates* (Closed) QIP progressed to the Outcomes stage. As indicated above, overall, the QIP was not successful at improving postpartum care rates, which suggests the MCP has opportunities to improve the timeliness of care provided to women in need of postpartum care.

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 2012–13 MCP-specific evaluation report. Anthem's self-reported responses are included in Appendix D.

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 at least a quarterly assessment of progress and making changes when indicated.
- Engage in the following efforts to improve performance on required performance measures:
  - In instances where rates have improved, assess the factors contributing to the improvement and duplicate the improvement strategies, as appropriate, across counties.
  - For measures with rates that continue to decline and for measures with rates below the MPLs, reassess the barriers to the MCP improving performance, prioritize the barriers, and identify rapid-cycle improvement strategies to target the prioritized barriers.
  - Continue quarterly evaluation of the MCP's improvement efforts so that effective strategies can be expanded and ineffective strategies can be modified or eliminated.
  - Continue to work with DHCS and the EQRO to identify priority areas for improvement and strategies that have the best chance at resulting in positive outcomes.
- Continue to implement strategies to ensure that all required documentation is included in the QIP Summary Form, including referencing the QIP Completion Instructions and previous QIP validation tools.

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

Table A.6.1 through Table A.6.9 provide two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the tables:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

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

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table A.6.1—HEDIS 2014 SPD Trend Table
Anthem—Alameda County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	15.98%	19.74%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	114.02	115.98	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	189.35	294.17	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	79.85%	83.77%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	75.70%	82.80%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	63.92%	78.70%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	84.46%	79.11%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	77.30%	70.43%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	35.04%	38.72%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	32.12%	34.96%	↔
Comprehensive Diabetes Care—HbA1c Testing	65.45%	77.88%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	31.14%	27.88%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	19.71%	19.91%	↔
Comprehensive Diabetes Care—LDL-C Screening	55.72%	66.81%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.40%	78.32%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	63.26%	66.15%	↔

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

Table A.6.2—HEDIS 2014 SPD Trend Table
Anthem—Contra Costa County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	23.00%	19.78%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	93.77	97.01	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	201.70	284.86	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.49%	81.38%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.72%	78.77%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	89.33%	89.36%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	77.78%	87.61%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	82.10%	83.50%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	56.67%	44.57%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	36.67%	36.00%	↔
Comprehensive Diabetes Care—HbA1c Testing	75.00%	76.57%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	43.33%	33.71%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.17%	33.71%	↔
Comprehensive Diabetes Care—LDL-C Screening	67.50%	69.71%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	76.67%	84.00%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	47.50%	58.29%	↔

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

Table A.6.3—HEDIS 2014 SPD Trend Table
Anthem—Fresno County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	16.79%	16.18%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	69.24	74.31	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	401.81	367.46	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.19%	83.57%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.44%	85.08%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	80.80%	84.85%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	81.52%	84.70%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	75.98%	79.00%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	56.20%	50.88%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	37.71%	39.82%	↔
Comprehensive Diabetes Care—HbA1c Testing	82.24%	78.98%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	43.31%	33.63%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	35.52%	28.54%	↓
Comprehensive Diabetes Care—LDL-C Screening	75.67%	74.56%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	84.91%	80.75%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	46.47%	51.55%	↔

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

Table A.6.4—HEDIS 2014 SPD Trend Table
Anthem—Kings County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	19.82%	S	▲
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	140.74	119.47	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	662.36	563.40	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.55%	82.43%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.28%	83.70%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	80.00%	80.00%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	95.92%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	84.93%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	57.14%	48.60%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	34.69%	42.46%	↔
Comprehensive Diabetes Care—HbA1c Testing	74.15%	72.63%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	39.46%	27.93%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	25.85%	24.02%	↔
Comprehensive Diabetes Care—LDL-C Screening	73.47%	69.27%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.23%	80.45%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	55.10%	64.80%	↔

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

Table A.6.5—HEDIS 2014 SPD Trend Table
Anthem—Madera County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	17.31%	S	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	95.08	98.73	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	542.71	509.81	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	78.72%	86.18%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.04%	84.62%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	90.48%	93.62%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	97.44%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	92.86%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	64.29%	62.84%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	59.18%	53.38%	↔
Comprehensive Diabetes Care—HbA1c Testing	91.84%	84.46%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	55.10%	42.57%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.67%	34.46%	↔
Comprehensive Diabetes Care—LDL-C Screening	76.53%	70.27%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.71%	82.43%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	34.69%	50.00%	▼

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

Table A.6.6—HEDIS 2014 SPD Trend Table
Anthem—Sacramento County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	15.52%	13.26%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	85.17	82.77	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	331.70	356.44	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	67.13%	82.21%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	85.29%	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	70.32%	83.72%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	88.37%	92.31%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	77.94%	78.10%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	83.54%	83.31%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	81.66%	79.13%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	57.18%	45.58%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	31.14%	38.94%	↑
Comprehensive Diabetes Care—HbA1c Testing	81.02%	75.66%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	53.04%	41.59%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	34.06%	30.09%	↔
Comprehensive Diabetes Care—LDL-C Screening	71.53%	67.70%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.54%	84.96%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	39.90%	47.12%	▼

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

Table A.6.7—HEDIS 2014 SPD Trend Table
Anthem—San Francisco County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	15.35%	17.38%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	89.99	95.72	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	349.50	373.20	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.49%	84.77%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.14%	84.60%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	NA	70.97%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	94.12%	77.50%	↓
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.78%	88.35%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.97%	55.33%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	47.52%	48.67%	↔
Comprehensive Diabetes Care—HbA1c Testing	87.17%	82.89%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	55.10%	44.67%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	41.11%	30.89%	↓
Comprehensive Diabetes Care—LDL-C Screening	76.68%	70.44%	↓
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.88%	84.00%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	34.40%	47.56%	▼

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

Table A.6.8—HEDIS 2014 SPD Trend Table
Anthem—Santa Clara County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	14.47%	16.33%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	62.01	74.19	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	364.03	374.95	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.02%	89.63%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.38%	88.49%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.16%	81.45%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.81%	86.89%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.01%	83.11%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	54.26%	40.84%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50.61%	43.93%	↓
Comprehensive Diabetes Care—HbA1c Testing	81.51%	84.33%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	49.39%	44.59%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	41.61%	37.09%	↔
Comprehensive Diabetes Care—LDL-C Screening	79.32%	79.91%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.37%	82.78%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	41.36%	46.58%	↔

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

Table A.6.9—HEDIS 2014 SPD Trend Table
Anthem—Tulare County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	15.70%	12.83%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	85.58	83.89	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	494.61	561.54	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.10%	85.94%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.27%	87.12%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	NA	NA	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	83.87%	89.09%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	81.43%	86.57%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	83.68%	86.76%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.02%	51.11%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	36.01%	42.70%	↑
Comprehensive Diabetes Care—HbA1c Testing	80.78%	83.19%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.96%	39.82%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	35.77%	29.42%	↓
Comprehensive Diabetes Care—LDL-C Screening	74.70%	71.46%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	84.18%	84.96%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	42.09%	47.79%	↔

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

Table B.1 through Table B.9 provide two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the "2013–14 Rate Difference" column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

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

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since there are fewer than 11 cases in the numerator of this measure, DHCS suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Table B.1—HEDIS 2014 Non-SPD Trend Table
Anthem—Alameda County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	9.84%	10.91%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	55.23	53.18	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	144.94	187.84	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	66.07%	71.79%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	62.94%	70.77%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	84.31%	85.30%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	67.90%	77.79%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	78.76%	78.54%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	77.69%	75.79%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	39.62%	46.33%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	33.46%	36.68%	↔
Comprehensive Diabetes Care—HbA1c Testing	63.08%	73.36%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	27.31%	27.41%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	16.92%	15.06%	↔
Comprehensive Diabetes Care—LDL-C Screening	50.38%	55.60%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	62.69%	66.02%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	65.77%	66.41%	↔

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

Table B.2—HEDIS 2014 Non-SPD Trend Table
Anthem—Contra Costa County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	8.89%	S	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	56.21	56.15	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	202.82	225.26	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	72.41%	76.47%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	58.00%	67.35%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.88%	95.23%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	84.85%	86.31%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	85.69%	88.35%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	82.84%	85.16%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	42.68%	48.96%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.46%	40.63%	↔
Comprehensive Diabetes Care—HbA1c Testing	60.98%	72.92%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	34.15%	40.63%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	21.95%	21.88%	↔
Comprehensive Diabetes Care—LDL-C Screening	59.76%	62.50%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	53.66%	68.75%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	60.98%	54.17%	↔

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

Table B.3—HEDIS 2014 Non-SPD Trend Table
Anthem—Fresno County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	10.55%	10.68%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	40.31	45.59	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	231.05	219.48	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	79.15%	81.76%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.81%	78.59%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	94.28%	93.86%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	82.89%	83.33%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	80.30%	83.46%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	76.57%	79.14%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.61%	54.57%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	40.63%	42.09%	↔
Comprehensive Diabetes Care—HbA1c Testing	71.53%	79.29%	↑
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	38.69%	33.85%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.20%	29.84%	↔
Comprehensive Diabetes Care—LDL-C Screening	66.42%	73.27%	↑
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.24%	75.95%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	54.74%	54.12%	↔

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

Table B.4—HEDIS 2014 Non-SPD Trend Table
Anthem—Kings County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	11.84%	S	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	61.10	61.93	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	337.12	291.39	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.82%	80.56%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.13%	68.66%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	95.01%	94.71%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	86.69%	83.36%	↓
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	84.26%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	84.62%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	59.63%	60.74%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	41.61%	38.04%	↔
Comprehensive Diabetes Care—HbA1c Testing	75.78%	72.39%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	37.89%	23.31%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	26.09%	14.72%	↓
Comprehensive Diabetes Care—LDL-C Screening	72.67%	67.48%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	68.94%	73.62%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	55.28%	65.03%	↔

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

Table B.5—HEDIS 2014 Non-SPD Trend Table
Anthem—Madera County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	2.50%	S	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	56.55	54.40	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	293.16	272.13	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	74.47%	81.82%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	65.79%	68.42%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	98.05%	98.45%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	88.48%	90.87%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	NA	90.58%	Not Comparable
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	NA	88.52%	Not Comparable
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	68.70%	59.06%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	51.91%	56.69%	↔
Comprehensive Diabetes Care—HbA1c Testing	79.39%	84.25%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	49.62%	44.09%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	29.77%	22.83%	↔
Comprehensive Diabetes Care—LDL-C Screening	70.23%	67.72%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	74.05%	78.74%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	37.40%	44.88%	↔

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

Table B.6—HEDIS 2014 Non-SPD Trend Table
Anthem—Sacramento County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.85%	8.70%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	47.88	48.19	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	190.39	191.26	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	60.90%	75.38%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	59.22%	70.27%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	93.23%	94.06%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	80.26%	81.70%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	81.02%	80.76%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	80.47%	78.05%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	55.96%	57.74%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	29.20%	32.30%	↔
Comprehensive Diabetes Care—HbA1c Testing	67.40%	70.80%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	37.71%	35.84%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	22.63%	25.22%	↔
Comprehensive Diabetes Care—LDL-C Screening	58.15%	61.50%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	61.07%	67.70%	↑
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	53.53%	52.88%	↔

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

Table B.7—HEDIS 2014 Non-SPD Trend Table
Anthem—San Francisco County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	6.56%	S	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	32.91	35.87	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	237.72	245.67	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	77.78%	82.42%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.13%	80.39%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.08%	96.95%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.28%	89.53%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	90.74%	89.73%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	89.69%	88.40%	↔
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	60.19%	66.04%	↔
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	39.81%	53.77%	↑
Comprehensive Diabetes Care—HbA1c Testing	84.47%	83.02%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	48.54%	40.57%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	31.07%	25.47%	↔
Comprehensive Diabetes Care—LDL-C Screening	73.79%	70.75%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.52%	75.47%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	37.86%	47.17%	↔

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

Table B.8—HEDIS 2014 Non-SPD Trend Table
Anthem—Santa Clara County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	12.43%	6.88%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	37.66	41.56	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	234.32	232.83	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.37%	83.51%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.21%	79.27%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	96.07%	95.97%	↔
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	87.40%	87.66%	↔
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	88.02%	89.89%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	87.64%	85.77%	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	66.42%	51.55%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	51.82%	46.90%	↔
Comprehensive Diabetes Care—HbA1c Testing	83.21%	83.19%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	52.31%	44.25%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	39.90%	39.16%	↔
Comprehensive Diabetes Care—LDL-C Screening	79.32%	78.54%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.81%	79.87%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	38.93%	42.04%	↔

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

Table B.9—HEDIS 2014 Non-SPD Trend Table
Anthem—Tulare County

Measure	2013	2014	2013–14 Rate Difference
All-Cause Readmissions—Statewide Collaborative QIP Measure	7.83%	8.22%	↔
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	38.85	39.20	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	278.32	305.19	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	75.69%	84.20%	↑
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	77.22%	81.50%	↔
Children & Adolescents' Access to Primary Care Practitioners—12 to 24 Months	92.49%	97.77%	↑
Children & Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	82.70%	90.38%	↑
Children & Adolescents' Access to Primary Care Practitioners—7 to 11 Years	79.53%	88.28%	↑
Children & Adolescents' Access to Primary Care Practitioners—12 to 19 Years	82.13%	87.56%	↑
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	67.88%	59.20%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	35.52%	41.46%	↔
Comprehensive Diabetes Care—HbA1c Testing	79.08%	81.82%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	46.47%	39.02%	↓
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	33.33%	30.60%	↔
Comprehensive Diabetes Care—LDL-C Screening	70.80%	74.06%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.56%	77.61%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	44.28%	48.12%	↔

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

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.[11] This process allows HSAG to evaluate each MCP's performance measure rates 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 Table 3.1 through Table 3.9)

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

[11] 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.

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.

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** = Some, but 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 =** Some, but 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.

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 audit/SPD medical survey 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 and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the 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 D. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

for Anthem Blue Cross Partnership Plan

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with Anthem's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table D.1—Anthem's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report

2012–13 External Quality Review Recommendation Directed to Anthem	Actions Taken by Anthem During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
1. Continue to work closely with DHCS on implementation and monitoring of the CAP, including conducting ongoing assessment of progress and making changes when indicated.	Anthem met with DHCS regarding the corrective action plan (CAP) in October 2013, November 2013, and May 2014. The quality management staff meets with Maureen Farrell from DHCS monthly to give updates on improvement plans and quality improvement projects for the CAP.
2. Engage in the following efforts to improve performance on required performance measures:	
a. 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.	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.
b. 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.	Quarterly updates submitted on April 30, 2014, provided an assessment of the barriers that contributed to the decline of measures during this time period. Interventions were identified and implemented in each Anthem county to improve performance.
c. Implement at least quarterly evaluation of progress on performance measure goals and modify, eliminate, or add improvement strategies based on evaluation results.	Anthem reports on the quality improvement projects quarterly to DHCS. These quarterly reports include: • Interim HEDIS results • Quarterly goals • Quarterly interventions to reach the set goals (Plan-Do-Study-Act cycle) • If previous quarter's goals were met • Goals/interventions planned in the following quarter In addition, Anthem meets monthly with Maureen Farrell from DHCS to review the improvement plans. Monthly HEDIS rates, goals, and interventions are presented as are planned goals and interventions for the next month.

2012–13 External Quality Review Recommendation Directed to Anthem	Actions Taken by Anthem During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
d. 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.	Anthem Blue Cross continues to work on identifying effective ways to approach improvement efforts. A complete barrier analysis, which included using data, was conducted for all counties with measures under the MPL. The barrier analysis revealed: • Incomplete lab results data • Vision data missing from vision providers • Providers not using the Immunization Registry regularly • PM160 Database not available to Anthem staff for research • Lack of timely and accurate Encounter Data from provider medical groups Anthem Blue Cross continues to develop improvement strategies designed to make the greatest impact based on the barrier analysis. Strategies include: • Developing a working relationship with lab vendors to ensure all lab results are collected • Developing a monthly or quarterly standard process for vision providers • Increasing participation with the Immunization Registry to improve administrative data • Working with Immunization Registry to obtain monthly uploads from the registry of current members • Working with new vendor to process the PM160 data into a workable format for Anthem staff • Forming encounter data workgroups to perform root cause analysis and recommend fixes Anthem Blue Cross ensures the ongoing evaluation of improvement strategies by periodic monitoring of activity statistics quarterly and annually. Progress is evaluated based on the HEDIS results.
3. Engage in the following efforts to improve performance on QIPs:	
a. Reference the QIP Completion Instructions to ensure all required documentation is included in the QIP Summary Form.	The QIP Completion Instructions are used to complete the QIP Summary Form. Any sections of the QIP that received a *Not Met* or *Partially Met* status in the QIP Validation reports were corrected and resubmitted to DHCS.
b. 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.	Barrier analysis is conducted each quarter to be included in the quarterly report submissions for each QIP measure for each county. Based on the analysis, interventions are modified or continued.

2012–13 External Quality Review Recommendation Directed to Anthem	Actions Taken by Anthem During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
4. Review the 2013 MCP-specific CAHPS®[12] results report and develop strategies to address the *Rating of All Health Care, Getting Needed Care,* and *Getting Care Quickly* priority areas.	2013 CAHPS results for *Rating of All Health Care, Getting Needed Care* and *Getting Care Quickly* all show the adult score increased from 2012 but remain within the QC 10th percentile. Results were presented at the quarterly Physician Quality Improvement Committee (PQIC) meeting.
5. 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.	For DHCS's data and the data Anthem submitted to HSAG, there were no long-term care (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. Note: As of June 2013, Anthem has implemented separate LTC encounter file transmissions. LTC records are now segregated from hospital/inpatient encounter records and are currently being transmitted monthly in distinct LTC encounter files for each county. 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 month(s) or in certain counties. Note that DHCS indicates its staff worked with Anthem in early 2013 to obtain previously omitted pharmacy records with July 2010 dates of service. As noted, a system issue was identified by Anthem's pharmacy vendor for the period affecting July 2010 dates of service. This was corrected and records resubmitted. Note: Anthem will continue to monitor pharmacy submission volumes and is working closely with its pharmacy benefits manager to monitor and identify any variances in monthly submission volumes. 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. Note: As of January 2014, Anthem has implemented changes to its encounter generation process to populate and include only NPI numbers, when available, on outbound encounter records for the provider types noted above. Previously, Anthem utilized NPI as well as other provider identifiers such as Provider Medicaid ID and license number, as outlined in the Encounter Data Layout Guide at that time.

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