Volume 2 of 9
Medi-Cal Managed Care Physical Health External Quality Review Technical Report

Contract Year 2023–24

Plan-Specific Information

Quality and Population Health Management
California Department of Health Care Services

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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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Medi-Cal Managed Care Physical Health Plan Name Abbreviations

Health Services Advisory Group, Inc. (HSAG) uses the following abbreviated Medi-Cal managed care health plan (MCP) and population-specific health plan (PSP) names in this volume.

- **AAH**—Alameda Alliance for Health
- **Aetna**—Aetna Better Health of California
- **AHF**—AIDS Healthcare Foundation
- **Anthem Blue Cross**—Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
- **Blue Shield Promise**—Blue Shield of California Promise Health Plan
- **CalOptima**—CalOptima
- **CalViva**—CalViva Health
- **CCAH**—Central California Alliance for Health
- **CCHP**—Contra Costa Health Plan
- **CenCal**—CenCal Health
- **CHG**—Community Health Group Partnership Plan
- **CHPIV**—Community Health Plan Imperial Valley
- **CHW**—California Health & Wellness Plan
- **GCHP**—Gold Coast Health Plan
- **Health Net**—Health Net Community Solutions, Inc.
- **HPSJ**—Health Plan of San Joaquin
- **HPSM**—Health Plan of San Mateo
- **IEHP**—Inland Empire Health Plan
- **Kaiser**—Kaiser Permanente
- **Kaiser NorCal**—Kaiser NorCal (KP Cal, LLC)
- **Kaiser SoCal**—Kaiser SoCal (KP Cal, LLC)
- **KHS**—Kern Health Systems, DBA Kern Family Health Care
- **L.A. Care**—L.A. Care Health Plan
- **Molina**—Molina Healthcare of California
- **Partnership**—Partnership HealthPlan of California
- **SCAN**—SCAN Health Plan
- **SCFHP**—Santa Clara Family Health Plan
- **SFHP**—San Francisco Health Plan

Commonly Used Abbreviations and Acronyms

- **AAS**—alternative access standards
- **ADT**—admit, discharge, and transfer
- **ANC**—annual network certification
- **APL**—All Plan Letter
- **ARD/AOR**—Authorized Representative Designation/Appointment of Representative
- **CAP**—corrective action plan
- **CBAS**—community-based adult services
- **CCM**—complex care management
- **CDPH**—California Department of Public Health
- **CFR**—Code of Federal Regulations
- **CMS**—Centers for Medicare & Medicaid Services
- **COVID-19**—coronavirus disease 2019
- **CPT**—Current Procedural Terminology
- **CSA**—customer service advocate
- **DBA**—doing business as
- **DDG**—Data De-Identification Guidelines
- **DHCS**—California Department of Health Care Services
- **D-SNP**—Dual Special Needs Plan
- **ECM**—enhanced care management
- **EDV**—encounter data validation
- **EHR**—electronic health record
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **FQHC**—federally qualified health center
- **HbA1c**—Hemoglobin A1c
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[1]
- **HIE**—Health Information Exchange
- **HPL**—high performance level
- **HPV**—human papillomavirus
- **HRA**—health risk assessment
- **HSAG**—Health Services Advisory Group, Inc.
- **IHA**—initial health appointment

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

- **IPA**—independent physician association
- **Lab**—laboratory
- **LOINC**—Logical Observation Identifiers Names and Codes
- **LTC**—long-term care
- **MCAS**—Managed Care Accountability Set
- **MCMC**—Medi-Cal Managed Care program
- **MCP**—managed care health plan
- **MCQMD**—Managed Care Quality and Monitoring Division
- **MH**—mental health
- **MPL**—minimum performance level
- **NAV**—network adequacy validation
- **NCQA**—National Committee for Quality Assurance
- **NOA**—Notice of Action
- **OB/GYN**—obstetrics/gynecology
- **P4P**—pay-for-performance
- **PCP**—primary care provider
- **PDSA**—Plan-Do-Study-Act
- **PHQ**—Patient Health Questionnaire
- **PIP**—performance improvement project
- **PIR**—provider information request
- **PMV**—performance measure validation
- **PPG**—participating physician group
- **PQI**—potential quality issue
- **PSP**—population-specific health plan
- **Q**—quarter
- **QIC**—Quality Improvement Committee
- **QIHEC**—Quality Improvement and Health Equity Committee
- **QOC**—quality of care
- **RN**—registered nurse
- **SFTP**—secure file transfer protocol
- **SMART**—Specific, Measurable, Achievable, Relevant, and Time-bound
- **SMH**—specialty mental health
- **SMI**—severely mentally impaired
- **SPD**—Seniors and Persons with Disabilities
- **STI**—sexually transmitted infection
- **SUD**—substance use disorder
- **SWOT**—Strengths, Weaknesses, Opportunities, Threats

- **UMC**—Utilization Management Committee
- **VSD**—Value Set Directory
- **WCM**—Whole Child Model
- **WIC**—Women, Infants, and Children Program

Introduction

The 2023–24 Medi-Cal Managed Care Physical Health External Quality Review Technical Report is an annual, independent, technical report produced by Health Services Advisory Group, Inc. (HSAG), the external quality review organization (EQRO) for the California Department of Health Care Services' (DHCS') Medi-Cal Managed Care program (MCMC). The purpose of this report is to provide a summary of the external quality review (EQR) activities for the DHCS contracted MCMC physical health plans (i.e., managed care health plans [MCPs] and population-specific health plans [PSPs]). This report will sometimes collectively refer to these MCPs and PSPs as "plans."

This Volume 2 of the *2023–24 Medi-Cal Managed Care External Quality Review Technical Report* includes the following plan-specific information:

- Appendix A—PSP-Specific Performance Measure Results
- Appendix B—Comparative Plan-Specific Performance Improvement Project (PIP) Information
- Appendix C—Plan-Specific EQR Assessments and Recommendations

Note that the statewide aggregate assessment of the MCMC for the federally mandated and optional EQR activities is included in Volume 1; comparative MCP-specific measurement year 2023 performance measure results are included in Volume 3; statewide and MCP-specific measurement year 2023 performance measure results stratified by race and ethnicity are included in Volume 4; comparative plan-specific compliance review scoring results are included in Volume 5; and validation of network adequacy results, including comparative MCP- and PSP-specific results for all audited network adequacy indicators are included in Volume 6.

Appendix A. Population-Specific Health Plan-Specific Performance Measure Results

This appendix provides performance measure results for the two PSPs, AIDS Healthcare Foundation (AHF) and SCAN Health Plan (SCAN). These two PSPs provide services to specialized populations; therefore, DHCS' performance measure requirements for them are different than its requirements for MCPs. Refer to Table 6.1 and Table 6.2 in Section 6 of *Volume 1 of 9* of this report ("Population-Specific Health Plan Performance Measures") for the required measurement year 2023 Managed Care Accountability Set (MCAS) measures for AHF and SCAN, respectively. Due to each PSP serving a specialized population, HSAG produces no aggregate information related to the PSP performance measures. Also, due to the PSPs serving separate, specialized populations, performance measure comparison across PSPs is not appropriate.

Table A.1 and Table A.2 provide performance measure results for measurement years 2021, 2022, and 2023 for AHF and SCAN, respectively.

Note the following regarding Table A.1 and Table A.2:

- High performance levels (HPLs) and minimum performance levels (MPLs) represent the 2023 National Committee for Quality Assurance (NCQA) Quality Compass®,[2] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively.

Please refer to Table 5.1 and Table 5.2 in Section 5 of *Volume 1 of 9* of this report ("Managed Care Health Plan Performance Measures") for the descriptions of all MCAS performance measures and the benchmarks HSAG used for HPL and MPL comparisons included in the applicable tables.

Table A.1—Measurement Years 2021, 2022, and 2023 Performance Measure Results AHF—Los Angeles County

and ↑ = Rate indicates performance at or better than the HPL.

Bolded Rate and ↓ = Rate indicates performance worse than the MPL.

and ▲= Statistical testing result indicates that the measurement year 2023 rate is significantly better than the measurement year 2022 rate.

and ▼ = Statistical testing result indicates that the measurement year 2023 rate is significantly worse than the measurement year 2022 rate.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

Measurement year 2022 rates reflect data from January 1, 2022, through December 31, 2022.

[2] Quality Compass® is a registered trademark of NCQA.

Measurement year 2023 rates reflect data from January 1, 2023, through December 31, 2023.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* For this measure, only the measurement years 2022 and 2023 rates are compared to the HPLs and MPLs based on DHCS' performance measure requirements.

^ A lower rate indicates better performance for this measure.

NA = The PSP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

— Indicates that the rate is not available.

Not Tested = A measurement year 2022–23 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Chronic Disease Management Domain (Measures held to MPLs.)				
Controlling High Blood Pressure—Total	63.56%	71.82%↑	64.22%	-7.60%
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)^*	26.15%↑	26.32%↑	22.47%↑	-3.84%
Behavioral Health Domain (Measures held to MPLs.)				
*Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—18 Years and Older**	NA	NA	NA	Not Tested
*Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—18 Years and Older**	NA	NA	NA	Not Tested
Report Only Measures (Measures not held to MPLs.)				
Adults' Access to Preventive/Ambulatory Health Services—Total	—	91.98%	93.02%	1.04%

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44	NA	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Ages 18–44 Years	—	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Ages 45–64 Years	—	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—65 Years and Older	—	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total	—	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Depression Remission—Ages 18–44 Years	—	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Depression Remission—Ages 45–64 Years	—	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Depression Remission—65 Years and Older	—	NA	NA	Not Tested

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Depression Remission or Response for Adolescents and Adults—Depression Remission—Total	—	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Depression Response—Ages 18–44 Years	—	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Depression Response—Ages 45–64 Years	—	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Depression Response—65 Years and Older	—	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Depression Response—Total	—	NA	NA	Not Tested
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—Ages 18–64 Years	—	30.04%	42.41%	12.37%▲
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—65 Years and Older	—	NA	NA	Not Tested
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—Total	—	30.36%	41.54%	11.18%▲

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—Ages 18–64 Years	—	NA	NA	Not Tested
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—65 Years and Older	—	NA	NA	Not Tested
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—Total	—	NA	NA	Not Tested
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—18 Years and Older	NA	NA	NA	Not Tested
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—18 Years and Older	NA	NA	NA	Not Tested
Pharmacotherapy for Opioid Use Disorder	—	NA	NA	Not Tested

Table A.2—Measurement Years 2021, 2022, and 2023 Performance Measure Results SCAN—Los Angeles/Riverside/San Bernardino/San Diego Counties

and ↑ = Rate indicates performance at or better than the HPL.

Bolded Rate and ↓ = Rate indicates performance worse than the MPL.

and ▲= Statistical testing result indicates that the measurement year 2023 rate is significantly better than the measurement year 2022 rate.

and ▼ = Statistical testing result indicates that the measurement year 2023 rate is significantly worse than the measurement year 2022 rate.

Measurement year 2021 rates reflect data from January 1, 2021, through December 31, 2021.

Measurement year 2022 rates reflect data from January 1, 2022, through December 31, 2022.

Measurement year 2023 rates reflect data from January 1, 2023, through December 31, 2023.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* For this measure, only the measurement years 2022 and 2023 rates are compared to the HPLs and MPLs based on DHCS' performance measure requirements.

^ A lower rate indicates better performance for this measure.

NA = The PSP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = HSAG suppressed displaying the rate to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

— Indicates that the rate is not available.

Not Tested = A measurement year 2022–23 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Cancer Prevention Domain (Measures held to MPLs.)				
Breast Cancer Screening—Total	77.09%↑	79.62%↑	80.55%↑	0.93%
Chronic Disease Management Domain (Measures held to MPLs.)				
Controlling High Blood Pressure—Total	68.46%↑	73.61%↑	75.61%↑	2.00%
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)^*	7.53%↑	13.60%↑	13.04%↑	-0.56%
Behavioral Health Domain (Measures held to MPLs.)				
*Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—65 Years and Older**	NA	NA	NA	Not Tested
*Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—65 Years and Older**	NA	NA	**35.85%↓**	Not Tested

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Report Only Measures (Measures not held to MPLs.)				
Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older	—	95.18%	95.62%	0.44%
Colorectal Cancer Screening	—	73.26%	73.17%	-0.09%
Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—65 Years and Older	—	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Depression Remission—65 Years and Older	—	NA	NA	Not Tested
Depression Remission or Response for Adolescents and Adults—Depression Response—65 Years and Older	—	NA	NA	Not Tested
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—65 Years and Older	—	0.00%	NA	Not Tested
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—65 Years and Older	—	NA	NA	Not Tested
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—65 Years and Older	NA	NA	NA	Not Tested

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022–23 Rate Difference
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—65 Years and Older	NA	NA	S	Not Tested
Pharmacotherapy for Opioid Use Disorder	—	NA	NA	Not Tested

Appendix B. Comparative Plan-Specific Performance Improvement Project Information

This appendix provides the PIP validation criteria and confidence level definitions that HSAG uses for validating PIPs. Additionally, this appendix includes MCP- and PSP-specific PIP topics and validation findings, as well as descriptions of plan-tested interventions.

PIP Validation Criteria

HSAG conducts PIP validation in accordance with the Centers for Medicare & Medicaid Services (CMS) *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[3]

Table B.1 lists the review steps and corresponding evaluation elements, including critical elements, that HSAG uses for validating each annual PIP submission. HSAG assigns a *Met/Partially Met/Not Met* score to each evaluation element.

Table B.1—Performance Improvement Project Validation Review Steps and Evaluation Elements

* Denotes a critical evaluation element.

Review Steps	Evaluation Elements
1. Review the Selected PIP Topic	♦ The PIP topic was selected following collection and analysis of data.*
2. Review the PIP Aim Statement(s)	♦ The PIP Aim statement(s) stated the area in need of improvement in clear, concise, and measurable terms.*
3. Review the Identified PIP Population	♦ The PIP population was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied.*

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 17, 2024.

Review Steps	Evaluation Elements
4. Review the Sampling Method	The sampling method: ♦ Included the sampling frame size for each indicator. ♦ Included the sample size for each indicator.* ♦ Included the margin of error and confidence level for each indicator. ♦ Described the method used to select the sample. ♦ Allowed for the generalization of results to the population.*
5. Review the Selected Performance Indicator(s)	The performance indicator(s): ♦ Were well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.* ♦ Included the basis on which the indicator(s) was developed, if internally developed.
6. Review the Data Collection Procedures	The data collection procedures included: ♦ Clearly defined sources of data and data elements collected for the indicator(s). ♦ A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s).* ♦ A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.* ♦ The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.
7. Review Data Analysis and Interpretation of Results	The data analysis and interpretation of the indicator outcomes: ♦ Included accurate, clear, consistent, and easily understood information in the data table.* ♦ Included a narrative interpretation of results that addressed all requirements. ♦ Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.
8. Assess the Improvement Strategies	The improvement strategies included: ♦ A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.* ♦ Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.*

Review Steps	Evaluation Elements
	♦ Interventions that were implemented in a timely manner to allow for impact of indicator outcomes. ♦ An evaluation of effectiveness for each individual intervention.* ♦ Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	♦ The remeasurement methodology was the same as the baseline methodology.* ♦ There was improvement over baseline performance across all performance indicators. ♦ There was statistically significant improvement (95 percent confidence level, *p* value of <0.05) over the baseline across all performance indicators. ♦ Sustained statistically significant improvement over baseline indicator performance across all indicators was demonstrated through repeated measurements over comparable time periods.

Confidence Level Definitions

HSAG assesses the validity and reliability of the results to determine whether plans, DHCS, and key stakeholders may have confidence in the reported PIP findings. For each annual PIP submission, HSAG determines the following confidence level(s), as applicable:

- Overall confidence of adherence to acceptable PIP methodology.
- Overall confidence that the PIP achieved significant improvement.

HSAG uses the following calculation to determine 1) the evaluation element score and 2) the critical element score, both of which HSAG uses to assign confidence levels related to adherence to an acceptable PIP methodology:

- The percentage score for all evaluation elements *Met* is calculated by dividing the total *Met* by the sum of all evaluation elements *Met, Partially Met,* and *Not Met*. The *Not Assessed* and *Not Applicable* results are removed from the scoring calculations.
- The percentage score for 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*.

HSAG assigns a confidence level for significant improvement only after the PIP demonstrates improvement over the baseline rate for the PIP performance indicator.

Table B.2 includes the definitions for the confidence levels HSAG assigns to each PIP submission.

Table B.2—Performance Improvement Project Confidence Level Definitions

Confidence Level	Definition
Overall Confidence of Adherence to Acceptable PIP Methodology	
High Confidence	All critical evaluation elements were *Met*, and 90 to 100 percent of all evaluation elements were *Met* across all steps.
Moderate Confidence	All critical evaluation elements were *Met*, and 80 to 89 percent of all evaluation elements were *Met* across all steps.
Low Confidence	Sixty-five to 79 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Partially Met*.
No Confidence	Less than 65 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Not Met*.
Overall Confidence that the PIP Achieved Significant Improvement	
High Confidence	All performance indicators demonstrated *statistically significant* improvement over the baseline.
Moderate Confidence	One of the three scenarios below occurred: 1. All performance indicators demonstrated improvement over the baseline, and some but not all performance indicators demonstrated *statistically significant* improvement over the baseline. 2. All performance indicators demonstrated improvement over the baseline, and none of the performance indicators demonstrated *statistically significant* improvement of the baseline. 3. Some but not all performance indicators demonstrated improvement over baseline, and some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
Low Confidence	The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator; or some but not all performance indicators demonstrated improvement over the baseline, and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.

Confidence Level	Definition
No Confidence	The remeasurement methodology was not the same as the baseline methodology for all performance indicators, or none of the performance indicators demonstrated improvement over the baseline.

Performance Improvement Project Validation Findings

The MCPs and PSPs began implementing the 2023–26 PIPs in April 2023. Section 3 of *Volume 1 of 9* of this EQR technical report ("Validation of Performance Improvement Projects") describes DHCS' requirements for the clinical and nonclinical PIP topics. HSAG conducted PIP validations on the PIP submission forms that the plans submitted in September 2023 and September 2024. The MCPs and PSPs submitted one form for each required PIP for each annual submission. The September 2023 submissions included information about the PIP design. The September 2024 submissions included baseline data (calendar year 2023) and documented improvement strategies implemented in 2024 up to the date of submission. HSAG validated each PIP submission using the validation criteria described in Table B.1 and assigned confidence levels as defined in Table B.2.

Note that in this section, the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure is referred to as *"W30-6,"* and the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure is referred to as *"W30-2."*

Table B.3 and Table B.4 list the plans' clinical and nonclinical PIP topics, evaluation element scores, critical element scores, and confidence levels for adherence to an acceptable PIP methodology for the September 2023 and September 2024 submissions, respectively.

Table B.3—September 2023 Performance Improvement Project Submission Evaluation Element Scores, Critical Element Scores, and Confidence Levels for Adherence to an Acceptable Methodology

Plan Name	PIP Topic	Evaluation Element Score	Critical Element Score	Confidence Level
Managed Care Health Plans				
AAH	*Improve the percentage of provider notifications for members with substance use disorder (SUD)/specialty mental health (SMH) diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
Anthem Blue Cross	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	25%	33%	No Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
Blue Shield Promise	*Improve the percentage of members enrolled into care management, complex care management (CCM), or enhanced care management (ECM) who have been diagnosed with SMH/SUD within 14 days of diagnoses*	100%	100%	High Confidence
	W30-6 measure rate among the Hispanic population	100%	100%	High Confidence
CalOptima	*Improve the percentage of members enrolled into care management, CCM, or ECM who have been diagnosed with SMH/SUD within 14 days of a provider (emergency department) visit where the member was diagnosed with SMH/SUD*	100%	100%	High Confidence

Plan Name	PIP Topic	Evaluation Element Score	Critical Element Score	Confidence Level
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
CalViva	*Improve the percentage of provider notifications for members with SUD/mental health (MH) diagnoses following or within seven days of an emergency department visit in Fresno and Madera counties*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population in Fresno County	100%	100%	High Confidence
CCAH	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Hispanic population in Merced County	83%	80%	Low Confidence
CCHP	*Improve the percentage of members enrolled into care management within 14 days of an emergency department visit where the member was diagnosed with SMH/SUD*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
CenCal	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Hispanic population	100%	100%	High Confidence
CHG	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or*	100%	100%	High Confidence

Plan Name	PIP Topic	Evaluation Element Score	Critical Element Score	Confidence Level
	within seven days of an emergency department visit			
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
GCHP	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Hispanic/Latinx population	100%	100%	High Confidence
Health Net	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population in Los Angeles, Sacramento, San Joaquin, Stanislaus, and Tulare counties	100%	100%	High Confidence
HPSJ	*Improve the percentage of provider notifications for members with SUD/severely mentally impaired (SMI) diagnoses following or within seven days of an emergency department visit*	67%	60%	Low Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
HPSM	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Hispanic or Latino population	100%	100%	High Confidence

Plan Name	PIP Topic	Evaluation Element Score	Critical Element Score	Confidence Level
IEHP	*Improve provider notifications for members with SUD and SMH diagnoses after emergency department visits*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
Kaiser	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
KHS	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
L.A. Care	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
Molina	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-2 measure rate among the Black/African-American population	100%	100%	High Confidence
Partnership	*Improve the percentage of provider notifications for members with SMH diagnoses following or within seven*	100%	100%	High Confidence

Plan Name	PIP Topic	Evaluation Element Score	Critical Element Score	Confidence Level
	days of an emergency department visit			
	W30-6 measure rate among the Black/African-American population in Solano County	100%	100%	High Confidence
SCFHP	*Improve the percentage of members enrolled into care management, CCM, or ECM within 14 days of a provider visit where the member was diagnosed with SMH/SUD*	100%	100%	High Confidence
	W30-6 measure rate among the Asian population	100%	100%	High Confidence
SFHP	*Improve the percentage of provider notifications for members with SUD diagnoses following or within seven days of an emergency department visit*	33%	20%	No Confidence
	W30-6 measure rate among the Hispanic or Latino population	100%	100%	High Confidence
Population-Specific Health Plans				
AHF	*Breast cancer screening*	100%	100%	High Confidence
	Improve the number of existing members with a diagnosis of SUD or SMH enrolled into case management	83%	80%	Low Confidence
SCAN	*Improving health risk assessment (HRA) rates to ensure better assessment of and access to community resources*	100%	100%	High Confidence
	Improving statin adherence in the Hispanic population	100%	100%	High Confidence

Table B.4—September 2024 Performance Improvement Project Submission Evaluation Element Scores, Critical Element Scores, and Confidence Levels for Adherence to an Acceptable Methodology

* DHCS' contract with CHPIV became effective January 1, 2024; therefore, the MCP did not have a full calendar year of data to calculate a baseline rate for either PIP. For both PIPs, the MCP submitted PIP design information only.

Plan Name	PIP Topic	Evaluation Element Score	Critical Element Score	Confidence Level
Managed Care Health Plans				
AAH	*Improve the percentage of provider notifications for members with SUD/ SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
Anthem Blue Cross	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	33%	33%	No Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
Blue Shield Promise	*Improve the percentage of members enrolled into care management, CCM, or ECM who have been diagnosed with SMH/SUD within 14 days of diagnoses*	100%	100%	High Confidence
	W30-6 measure rate among the Hispanic population	100%	100%	High Confidence
CalOptima	*Improve the percentage of members enrolled into care management, CCM, or ECM who have been diagnosed with SMH/SUD within 14 days of a provider (emergency department) visit where the member was diagnosed with SMH/SUD*	73%	78%	Low Confidence

Plan Name	PIP Topic	Evaluation Element Score	Critical Element Score	Confidence Level
	W30-6 measure rate among the Black/African-American population	80%	89%	Low Confidence
CalViva	*Improve the percentage of provider notifications for members with SUD/MH diagnoses following or within seven days of an emergency department visit in Fresno and Madera counties*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population in Fresno County	93%	100%	High Confidence
CCAH	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	80%	78%	Low Confidence
	W30-6 measure rate among the Hispanic population in Merced County	93%	89%	Low Confidence
CCHP	*Improve the percentage of members enrolled into care management within 14 days of an emergency department visit where the member was diagnosed with SMH/SUD*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
CenCal	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Hispanic population	100%	100%	High Confidence

Plan Name	PIP Topic	Evaluation Element Score	Critical Element Score	Confidence Level
CHG	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	87%	89%	Low Confidence
	W30-6 measure rate among the Black/African-American population	87%	100%	Moderate Confidence
CHPIV*	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Hispanic population	100%	100%	High Confidence
GCHP	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Hispanic/Latinx population	93%	89%	Low Confidence
Health Net	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population in Los Angeles, Sacramento, San Joaquin, Stanislaus, and Tulare counties	94%	89%	Low Confidence
HPSJ	*Improve the percentage of provider notifications for members with SUD/ SMI diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence

Plan Name	PIP Topic	Evaluation Element Score	Critical Element Score	Confidence Level
	W30-6 measure rate among the Black/African-American population	87%	89%	Low Confidence
HPSM	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Hispanic or Latino population	100%	100%	High Confidence
IEHP	*Improve provider notifications for members with SUD and SMH diagnoses after emergency department visits*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
Kaiser	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	87%	78%	Low Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence
KHS	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	71%	89%	Low Confidence
	W30-6 measure rate among the Black/African-American population	93%	89%	Low Confidence
L.A. Care	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population	100%	100%	High Confidence

Plan Name	PIP Topic	Evaluation Element Score	Critical Element Score	Confidence Level
Molina	*Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within seven days of an emergency department visit*	100%	100%	High Confidence
	W30-2 measure rate among the Black/African-American population	100%	100%	High Confidence
Partnership	*Improve the percentage of provider notifications for members with SMH diagnoses following or within seven days of an emergency department visit*	93%	100%	High Confidence
	W30-6 measure rate among the Black/African-American population in Solano County	100%	100%	High Confidence
SCFHP	*Improve the percentage of members enrolled into care management, CCM, or ECM within 14 days of a provider visit where the member was diagnosed with SMH/SUD*	100%	100%	High Confidence
	W30-6 measure rate among the Asian population	93%	89%	Low Confidence
SFHP	*Improve the percentage of provider notifications for members with SUD diagnoses following or within seven days of an emergency department visit*	80%	89%	No Confidence
	W30-6 measure rate among the Hispanic or Latino population	100%	100%	High Confidence
Population-Specific Health Plans				
AHF	*Breast cancer screening*	47%	67%	No Confidence
	Improve the number of existing members with a diagnosis of SUD or SMH enrolled into case management	40%	56%	No Confidence

Plan Name	PIP Topic	Evaluation Element Score	Critical Element Score	Confidence Level
SCAN	*Improving HRA rates to ensure better assessment of and access to community resources*	79%	67%	Low Confidence
	Improving statin adherence in the Hispanic population	80%	78%	Low Confidence

Performance Improvement Project Interventions

Table B.5 and Table B.6 present descriptions of interventions that the plans tested as described in the September 2024 PIP submissions for clinical and nonclinical PIPs, respectively. The tables also provide each PIP's performance indicator description and the baseline rate (calendar year 2023).

Table B.5—2023–26 Clinical Performance Improvement Project Intervention Descriptions, Performance Indicator Descriptions, and Baseline Rates

S = HSAG suppressed displaying the rate to satisfy the DHCS DDG V2.2 de-identification standard.

Plan Name	Intervention Description	PIP Performance Indicator Description	Baseline Rate
Topic: *W30-6* Measure Rate among the Black/African-American Population			
AAH	♦ Conduct member outreach and education on well-child screenings and transportation services.	The percentage of African-American children who met the *W30-6* measure requirements.	40.59%
Anthem Blue Cross	♦ Have community health workers provide preventive health care navigation services to caregivers of members to support completion of six well-child visits within the first 15 months of life.	The percentage of Black/African-American members up to 15 months of age completing six or more well-child visits.	38.10%
CalOptima	♦ Have health educators outreach to parents/guardians of members to coordinate well-child visits.	The percentage of Black/African-American children who turned 15 months old during the measurement year who completed six or more well-child	45.05%

Plan Name	Intervention Description	PIP Performance Indicator Description	Baseline Rate
		visits with a primary care provider (PCP) on different dates of service on or before the child's 15-month birthday.	
CalViva	♦ Refer eligible members to the Black Infant Health Program, which offers comprehensive clinical and nonclinical support to pregnant and postpartum moms, including assistance with coordinating babies' well-child visits.	The percentage of Black/African-American children enrolled in Fresno County turning 15 months during the measurement year who completed six or more well-child visits with a PCP before turning 15 months of age.	31.30%
		The percentage of Black/African-American members enrolled in Fresno County who completed three or more infant well-child visits with a PCP by 120 days of life.	41.50%
CCHP	♦ Conduct outreach to parents/guardians of eligible members and offer appointment scheduling assistance.	The percentage of Black members who had at least six well-child visits with a PCP in the first 15 months of life.	71.60%
CHG	♦ Implement pay-for-performance (P4P) provider incentive to encourage providers to complete well-child visits for eligible members. ♦ Implement member incentive to conduct outreach and health education to parents/guardians of eligible members to complete well-child visits.	The percentage of Black/African-American members who had six or more well-child visits within the first 15 months of life among members who turned 15 months old during the measurement year.	32.20%

Plan Name	Intervention Description	PIP Performance Indicator Description	Baseline Rate
Health Net	♦ Refer eligible members to the Black Infant Health Program, which offers comprehensive clinical and nonclinical support to pregnant and postpartum moms, including assistance with coordinating babies' well-child visits.	The percentage of Black/African-American children enrolled in Los Angeles, Sacramento, San Joaquin, Stanislaus, or Tulare counties turning 15 months during the measurement year who completed six or more well-child visits with a PCP before turning 15 months of age.	35.26%
		The percentage of Black/African-American members enrolled in Los Angeles, Sacramento, San Joaquin, Stanislaus, or Tulare counties who completed three or more infant well-care visits with a PCP by 120 days of life.	30.35%
HPSJ	♦ Reinforce MyRewards incentive with providers to increase engagement of Black/African-American members. ♦ Provide training to provider partners to increase distribution of population-specific milestone booklets to Black/African-American members. ♦ Conduct member outreach calls to parents/guardians of Black/African-American members 0 to 12 months old with zero to five total visits.	The percentage of Black/African-American members who turned 15 months during the measurement year and who completed six or more well-child visits in the measurement year.	39.78%
IEHP	♦ Refer eligible members to the Black Infant Health Program, which offers comprehensive clinical and nonclinical support to pregnant and postpartum moms, including assistance with coordinating babies' well-child visits.	The percentage of Black/African-American members (reported via the DHCS 834 file) who received six or more well-child visits on or before their 15-month birthday.	47.31%

Plan Name	Intervention Description	PIP Performance Indicator Description	Baseline Rate
Kaiser	♦ Conduct targeted monthly outreach to Black/African-American children 0 to 15 months of age at Kaiser Permanente Northern California. ♦ Conduct text/call reminder outreach to eligible members in Southern California to schedule 14-month well-child visits. ♦ Conduct reminder letter outreach to eligible members in Southern California to schedule 12-month well-child visits.	The percentage of Black/African-American members 31 days to 15 months of age who completed six or more well-child visits with a PCP during the measurement year.	71.45%
KHS	♦ Implement mobile well-child visit clinics and use various platforms to promote the events to the eligible population. ♦ Conduct outreach to parents/guardians of eligible members and offer appointment scheduling and transportation assistance.	The percentage of Black/African-American members who had at least six well-child visits with a PCP during the first 15 months of life.	33.33%
L.A. Care	♦ Have community health coordinators conduct outreach calls to parents/guardians of eligible members.	The percentage of Black/African-American members residing in Service Planning Area 6 who completed six or more well-child visits on or before their 15-month birthday on different dates of service during the measurement year.	31.49%
Partnership	♦ Improve the internal process for conducting phone outreach by having an improvement advisor export all admit, discharge, and transfer (ADT) records for members who have delivered a baby to a wellness guide liaison who will call	The percentage of Black/African-American members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.	28.82%

Plan Name	Intervention Description	PIP Performance Indicator Description	Baseline Rate
	members on the list within 72 hours. ♦ Have the wellness guide liaison assist members with completing the Newborn PCP selection form during outreach calls with members.		
Topic: *W30-6* Measure Rate among the Hispanic or Latino Population			
Blue Shield Promise	♦ Have Spanish-speaking health navigators conduct outreach to parents/guardians to provide culturally relevant health education and assist with scheduling well-child visit appointments. ♦ Work with a vendor to conduct outreach and implement well-child visit clinic days and telehealth visits.	The percentage of Hispanic members 0 to 15 months of age during the measurement year who completed six or more well-child visits on different dates of service on or before their 15-month birthday.	49.82%
CCAH	♦ Provide financial support to a clinic site to hire a locum provider and offer extended clinic hours to close care gaps for well-child visits, particularly for Hispanic members.	The percentage of members who had six or more well-child visits with a PCP on different dates of service on or before their 15-month birthday based on Healthcare Effectiveness Data and Information Set (HEDIS®)[4] *W30-6* measure specifications.	48.39%
CenCal	♦ Improve demographic data accessibility by including demographic information in gaps-in-care and opportunity reports CenCal makes available to its providers via the provider portal.	The percentage of Hispanic/Latino members in Santa Barbara and San Luis Obispo counties who received six or more well-child visits on different dates of service on or before their 15-month birthday.	63.86%

[4] HEDIS® is a registered trademark of NCQA.

Plan Name	Intervention Description	PIP Performance Indicator Description	Baseline Rate
GCHP	♦ Host a frequently asked question session through Facebook Live, recorded both in English and Spanish. ♦ Host a lunch and learn session for GCHP's network providers, focusing on well-child visit clinical practices. ♦ Sponsor a community health fair and provide members with materials on well-child visits. ♦ Collaborate with two clinic partners to host Saturday health fairs to provide well-child visits to members. ♦ Identify opportunities for community-based organization partnerships. ♦ Collaborate with a large, local health system to co-brand member health promotion materials focused on well-child visits and immunization periodicity schedules in the first three years of life.	The percentage of Hispanic/Latinx members who completed six or more well-child visits with a PCP by 15 months of life.	62.93%
HPSM	♦ Implement a home visiting program. ♦ Develop a new provider incentive program using the Stellar software system to award providers who schedule appointments, complete well-child visits, and submit claims.	The percentage of Hispanic members who had six or more well-child visits with a PCP during the first 15 months of life.	61.95%
SFHP	♦ Partner with a promotora community-based organization to co-host health education workshops for members that focus on infant health, accessing eligible plan benefits/services, and	The percentage of Hispanic children who received six or more well-child visits on different dates of service on or before their 15-month birthday.	46.67%

Plan Name	Intervention Description	PIP Performance Indicator Description	Baseline Rate
	questions/concerns to discuss with providers. ♦ Partner with University of California San Francisco to co-host community health events for eligible populations.		
Topic: *W30-6* Measure Rate among the Asian Population			
SCFHP	♦ Send newborn reports to delegate groups and communicate and request updates from the delegates during monthly quality calls. ♦ Conduct outreach calls and discuss call data during monthly outreach meetings to determine outreach effectiveness.	The percentage of Asian members who turned 15 months of age during the measurement year who completed at least six well-child visits.	57.91%
Topic: *W30-2* Measure Rate among the Black/African-American Population			
Molina	♦ Create a workflow with the provider partner to improve race/ethnicity data collection and maintain a supplemental data feed with the provider partner to collect member demographic data.	The percentage of Black/African-American members who have two or more well-child visits on different dates of service between the child's 15-month plus 1 day and 30-month birthdays.	42.51%
Topic: Breast Cancer Screening			
AHF	♦ Create culturally and linguistically appropriate outreach materials for the target population to enhance the referral follow-up process and transportation access.	The percentage of female members 50 to 74 years of age who had a mammogram.	S
Topic: Improving Statin Adherence among the Hispanic Population			
SCAN	♦ Use the pharmacy platform to provide medication refill assistance for members who are five to seven days away from their refill due date.	The percentage of eligible Hispanic members 18 years of age or older who were adherent to their statin medications.	91.50%

Plan Name	Intervention Description	PIP Performance Indicator Description	Baseline Rate
	♦ Complete a barrier assessment and provide pharmacist medication adherence counseling to discuss potential medication side effects with the member.		

Table B.6—2023–26 Nonclinical Performance Improvement Project Intervention Descriptions, Performance Indicator Descriptions, and Baseline Rates

S = HSAG suppressed displaying the rate to satisfy the DHCS DDG V2.2 de-identification standard.

Plan Name	Intervention Description	Performance Indicator Description	Baseline Rate
Topic: Improve the Percentage of Provider Notifications for Members with SUD/SMH Diagnoses Following or Within Seven Days of an Emergency Department Visit			
AAH	♦ Provide ADT report via secure file transfer protocol (SFTP) site daily to providers to use for follow-up with members who qualify to be included in the *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* and *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measures. ♦ Provide an emergency department claims data report via SFTP site to providers to use to outreach to members who are eligible for follow-up.	The percentage of *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* measure-eligible emergency department visits for which providers received notification within seven days.	5.83%
		The percentage of *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure-eligible emergency department visits for which providers received notification within seven days.	5.25%

Plan Name	Intervention Description	Performance Indicator Description	Baseline Rate
Anthem Blue Cross	♦ Collaborate with three facilities to establish a process for notifying providers after a member has been seen in the emergency department for SUD or SMH diagnoses. ♦ Use daily ADT notification reports for a community health worker to outreach to appropriate providers to notify of members' emergency department visit. ♦ Use daily ADT notification reports for a community health worker to outreach to members regarding their recent emergency department visit and needed follow-up visit.	Provider notifications for members ages 18 years and older with SUD/SMH diagnoses following or within seven days of an emergency department visit in Tulare County.	0.00%
		Anthem provider notifications for members ages 18 years and older with SUD/SMI diagnoses following emergency department visits in Tulare County.	0.00%
		Outreach for members ages 18 years and older with SUD/SMI diagnoses following emergency department visits in Tulare County.	0.00%
CalViva	♦ Work with an identified local organization to conduct cultural sensitivity and implicit bias training to partner medical center staff members to increase knowledge on how to work with Hispanic members who are initiating behavioral health treatment.	The percentage of timely provider notifications in Fresno and Madera counties as indicated by data/documentation demonstrating that a qualified provider (e.g., PCP, PCP Team, specialist, licensed clinical social worker, or marriage and family therapist) received notification from hospital staff members regarding the patient's SUD/MH emergency department visit within seven calendar days of the SUD/MH emergency department date of service.	13.78%
CCAH	♦ Implement a timely automated provider notification system for members with an SUD/SMH diagnosis who are seen in the emergency department.	The percentage of emergency department visit notifications sent to providers for members with SUD/SMH diagnoses within seven days of an emergency department visit.	0.00%

Plan Name	Intervention Description	Performance Indicator Description	Baseline Rate
CenCal	♦ Create a standardized report that is available for PCPs via the provider portal to provide information on members being seen in the emergency department for SUD and SMH.	The percentage of notifications sent to PCPs within seven days of an emergency department visit for members with SUD/SMH diagnoses.	0.00%
CHG	♦ Collaborate with a hospital partner to improve CHG's data collection from the hospital. ♦ Contract with an alternative health information exchange (HIE) vendor to determine the feasibility for improving the timeliness and completeness of data exchange. ♦ Complete in-person meetings with local hospital leadership teams to discuss methods for obtaining data directly from the hospitals.	The percentage of notifications within seven days of the date of service for an emergency department visit for a principal diagnosis of mental illness, intentional self-harm, SUD, or any diagnosis of drug overdose.	37.32%
GCHP	♦ Implement a process to obtain daily emergency department encounter data from a medical center that includes emergency department visits for SMH conditions. ♦ Implement a process to obtain daily emergency department encounter data from a health system. ♦ Implement a process to automate the consolidation of the members identified with a SUD/SMH condition from the three data sources into one report that is generated daily (from Monday through Friday).	The percentage of members with a SUD/SMH condition who had a provider notification transmitted to their PCPs within seven days of the emergency department visit.	30.67%

Plan Name	Intervention Description	Performance Indicator Description	Baseline Rate
Health Net	♦ Develop and implement an additional feed in Cozeva to provide timely provider notification to providers regarding adult members with SMH emergency department visits. ♦ Have plan providers outreach to all eligible members who had a behavioral health emergency department visit.	The percentage of successful and timely provider notifications for emergency department visits with a SUD/SMH diagnosis among members in Sacramento, Los Angeles, San Joaquin, Stanislaus, and Tulare counties.	1.23%
HPSJ	♦ Research members' contact information from alternative sources, such as PCP, pharmacy, and hospital face sheets, to provide the information to members' PCP/federally qualified health center (FQHC) for outreach.	The percentage of providers receiving notification within seven days of members with an emergency department visit for SMI/SUD.	52.45%
HPSM	♦ Pilot a provider notification system with a cohort of providers for members seen at one of the project pilot hospitals, and documented in the PointClickCare Software program, following or within seven days of emergency department visits.	The percentage of provider notifications completed by HPSM to a member's behavioral health provider or PCP within seven days of an emergency department visit with an SUD or SMH principal diagnosis.	0.00%
IEHP	♦ Improve the provider notification process between the plan and providers to ensure timely notification with appropriate information for providers to conduct outreach to eligible members.	The percentage of emergency department events with a principal diagnosis of SUD, any diagnosis of drug overdose, or a principal diagnosis of mental illness or intentional self-harm wherein IEHP issued a provider notification within seven days of the member's emergency department visit.	0.00%

Plan Name	Intervention Description	Performance Indicator Description	Baseline Rate
Kaiser	♦ Identify pilot sites to conduct a Plan-Do-Study-Act (PDSA) cycle to improve the provider notification process for members with a SUD or SMH diagnosis following or within seven days of an emergency department visit.	The percentage of members ages 13 years and older who were seen in an emergency department with a principal SUD diagnosis or any diagnosis of drug overdose and ages 6 years and older who were seen in an emergency department with a principal SMH diagnosis or intentional self-harm for which there was a successful provider notification within seven days of the emergency department visit.	47.67%
KHS	♦ Improve the type of information disseminated to appropriate providers within seven days of a member's emergency department visit. ♦ Provide training to providers regarding the ADT report. ♦ Collaborate with a hospital partner to obtain information for emergency department visits due to SUD/SMH diagnosis for the ADT report.	The percentage of provider notifications for members ages 6 years and older with a principal diagnosis of mental illness or intentional self-harm and for members ages 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose following or within seven days of an emergency department visit during the measurement year.	39.09%
L.A. Care	♦ Send the completed SUD/SMH custom PointClickCare report to the provider portal for all direct network providers and medical groups to view and receive usage reports from the provider portal showing how many/who has viewed their report.	The percentage of provider notifications made within seven days of an emergency department visit for members who visited an emergency department with a SUD (members ages 13 years and older) or SMH (members ages 6 years and older) diagnosis.	0.00%

Plan Name	Intervention Description	Performance Indicator Description	Baseline Rate
Molina	♦ Convert raw emergency department data from the PointClickCare database using a refined and filterable report to create a user-friendly format.	The percentage of provider notifications issued within seven days of discharge during the measurement period for members ages 13 years and older who had emergency department visits with a principal diagnosis of SUD, or any diagnosis of drug overdose, and members ages 6 years and older who had emergency department visits with a principal diagnosis of mental illness or intentional self-harm.	7.62%
Partnership	♦ Implement a PCP notification workflow based on daily ADT reports and appropriate member outreach channels.	The percentage of emergency department visits for members ages 6 years and older (as of the date of the emergency department visit) with an SMH diagnosis with a PCP provider notification within seven days of the emergency department visit during the measurement period.	S
SFHP	♦ Facilitate communication between emergency departments and PCPs by providing emergency departments with members' assigned PCP information via a bar code and providing PCPs with a weekly list of members who had emergency department visits. ♦ Have emergency department navigators schedule same-day follow-up appointments with members' PCPs.	The percentage of emergency department visits for members 13 years of age and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which a notification of the emergency department visit was sent to the members' PCPs.	81.01%

Plan Name	Intervention Description	Performance Indicator Description	Baseline Rate
Topic: Improve the Percentage of Members Enrolled into Care Management, CCM, or ECM within 14 Days of a Provider Visit Wherein the Member Was Diagnosed with SUD/SMH.			
Blue Shield Promise	♦ Create outreach lists from ADT data for vendors to make three telephonic attempts to outreach to members and enroll members into ECM.	The percentage of members ages 6 years and older who had an emergency department visit with a principal diagnosis of mental illness or SUD who enrolled into care management, complex case management, or enhanced care management programs within 14 days after the emergency department visit.	2.14%
CalOptima	♦ Develop a process to refer identified members from real-time emergency department visit data to provide linkages and coordination of care by referring members to ECM, care management, or CCM.	The percentage of members ages 21 years or older identified by an emergency department visit with a diagnosis of SMH/SUD who were enrolled into care management, CCM, or ECM. The members should be enrolled within 14 days of the emergency department visit.	1.08%
CCHP	♦ Use access line linkage to improve patient care coordination and ECM enrollment. ♦ Implement automatic referrals for ECM/care management staff members to outreach to eligible members.	The percentage of members enrolled into care management within 14 days of an emergency department visit for a SMH/SUD diagnosis.	0.90%
SCFHP	♦ Develop a process to share member referral information to enroll members into a care management, ECM, or CCM program within 14 calendar days of the initial behavioral health diagnosis of MH/SUD.	The percentage of members enrolled in a care management program within 14 calendar days of an initial behavioral health diagnosis of SMH/SUD.	S

Plan Name	Intervention Description	Performance Indicator Description	Baseline Rate
Topic: Improve the Number of Existing Members with a Diagnosis of SUD or SMH Enrolled into Case Management			
AHF	♦ Develop a referral system and implement data tracking to monitor member enrollment into case management.	The percentage of members with a diagnosis of SUD or SMH who were enrolled into case management.	70.27%
Topic: Improve HRA Rates to Ensure Better Assessment of and Access to Community Resources			
SCAN	♦ Redesign HRA questions to incorporate feedback on challenges and barriers, and regulatory requirements.	The percentage of Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) members who completed a timely HRA in the measurement year.	81.20%

Appendix C. Plan-Specific External Quality Review Assessments and Recommendations

This appendix includes each MCP's and PSP's self-reported follow-up on the 2022–23 EQR recommendations and HSAG's assessment of the self-reported actions. Additionally, based on its assessment of the 2023–24 EQR activities, HSAG summarizes each plan's strengths and weaknesses (referred to as "opportunities for improvement" in this appendix) with respect to the quality, timeliness, and accessibility of care the plan furnishes to its members. Based on the assessment, HSAG makes recommendations to each plan.

Description of the Manner in Which MCP and PSP Data Were Aggregated and Analyzed and Conclusions Drawn Related to Quality, Timeliness, and Access

HSAG used the following process to aggregate and analyze data from all applicable EQR activities it conducted to draw conclusions about the quality, timeliness, and accessibility of care furnished by each plan. For each plan:

- HSAG analyzed the quantitative results obtained from each EQR activity to identify strengths and weaknesses related to the quality, timeliness, and accessibility of care furnished by the plan and to identify any themes across all activities.
- From the aggregated information collected from all EQR activities, HSAG identified strengths and weaknesses related to the quality, timeliness, and accessibility of services furnished by the plan.
- HSAG drew conclusions based on the identified strengths and weaknesses, specifying whether the strengths and weaknesses affect one aspect of care more than another (i.e., quality, timeliness, and accessibility of care).

Aetna Better Health of California

Follow-Up on Prior Year Recommendations

Aetna's contract with DHCS ended December 31, 2023; therefore, HSAG made no 2022–23 EQR recommendations to the plan since Aetna was not under contract with DHCS in July 2024 when HSAG requested summaries of how plans addressed the 2022–23 EQR recommendations.

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Aetna

While Aetna's contract with DHCS ended December 31, 2023, DHCS required the plan to participate in the measurement year 2023 performance measure validation (PMV) and validation of network adequacy audit processes. HSAG therefore identified strengths and opportunities for improvement based on the results of these activities; however, because Aetna is no longer under contract with DHCS, HSAG makes no recommendations to the plan.

Based on the overall assessment of Aetna's delivery of quality, timely, and accessible care through the 2023–24 EQR activities in which the plan participated, HSAG identified the following strengths and opportunities for improvement. Note that all of Aetna's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- For all rates except the Seniors and Persons with Disabilities (SPD) and non-SPD rates, the HSAG auditor determined that Aetna followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- For Sacramento County, Aetna performed above the HPL in measurement year 2023 for the *Chlamydia Screening in Women—Total* measure.
- During the network adequacy validation (NAV) audit process, Aetna provided documentation of the Information Systems Capabilities Assessment Tool (ISCAT) and supporting documentation in a timely manner, and all documentation was complete. Additionally, HSAG identified no specific opportunities for improvement related to Aetna's data collection and management processes used to inform network adequacy standard and indicator calculations.

Opportunities for Improvement

- Aetna did not accurately calculate the age stratifications for the SPD and non-SPD populations, resulting in the auditor determining that the MCP's SPD and non-SPD rates were biased.
- Across both reporting units in measurement year 2023, Aetna performed below the MPLs for 28 of the 36 measure rates that HSAG compared to benchmarks (78 percent).

2023–24 External Quality Review Recommendations

Aetna's contract with DHCS ended December 31, 2023; therefore, HSAG makes no recommendations to the MCP since Aetna will not be under contract with DHCS in July 2025 when HSAG requests summaries of how MCPs addressed the 2023–24 EQR recommendations.

AIDS Healthcare Foundation

Follow-Up on Prior Year Recommendations

HSAG provided each physical health plan an opportunity to outline actions taken to address the 2022–23 EQR recommendations. Based on HSAG's assessment of AHF's delivery of quality, timely, and accessible care through the activities described in the 2022–23 EQR technical report, HSAG included no recommendations for the PSP. Therefore, AHF had no recommendations that required the PSP to provide self-reported actions.

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for AHF

Based on the overall assessment of AHF's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of AHF's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned a *High Confidence* level to AHF's 2023 clinical PIP submission, reflecting that the PSP built a robust foundation in the Design stage of its clinical PIP.
- The HSAG auditor determined that AHF followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- AHF performed above the HPL in measurement year 2023 for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure.
- DHCS' 2024 compliance review scores for AHF show that the PSP was fully compliant with most CFR standards.
- During the NAV audit process, AHF demonstrated its capability of maintaining an adequate provider network to service members, and AHF utilized a subcontractor-provided data management service, LexisNexis, to validate provider data to ensure accuracy. Additionally, HSAG identified no specific opportunities for improvement related to AHF's data collection and management processes used to inform network adequacy standard and indicator calculations.

Opportunities for Improvement

- HSAG's 2024 PIP validation determined that AHF failed to include all required details of its PIP processes for both clinical and nonclinical PIPs.
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for AHF:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Quality Assessment and Performance Improvement Program—§438.330

20223–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure AHF includes all required information in the PSP's 2025 annual clinical and nonclinical PIP submissions.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure AHF meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Quality Assessment and Performance Improvement Program—§438.330

AHF's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate continued successes of AHF as well as the plan's progress with addressing these recommendations.

Alameda Alliance for Health

Follow-Up on Prior Year Recommendations

Table C.1 provides the 2022–23 EQR recommendations directed to AAH, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.1 to preserve the accuracy of AAH's self-reported actions.

Table C.1—AAH's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to AAH	Actions Taken by AAH to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure AAH meets all Code of Federal Regulations (CFR) standard requirements moving forward.	AAH worked to resolve the findings identified from DHCS' compliance review scoring related to the following standards: Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Grievance and Appeals Systems, Enrollee Rights, and Emergency and Poststabilization Services. The MCP updated policies and procedures and implemented additional monitoring and oversight processes to address the findings identified in the DHCS compliance review. AAH also conducted additional staff training for processes impacted by the deficiencies. Finally, AAH acknowledged staffing challenges and increased staffing to meet needs expected to remediate the deficiencies. AAH received the official corrective action plan (CAP) closure notification on April 26, 2024, for the 2023 DHCS Medical Audit. DHCS has accepted all corrective actions.

2022–23 External Quality Review Recommendations Directed to AAH	Actions Taken by AAH to Address the External Quality Review Recommendations
2. For measures for which AAH performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. a. For the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure, assess whether the MCP's provider education and member outreach strategies need to be revised to increase the percentage of members turning 15 months old who complete six or more well-child visits.	**Addressing the Following Measures with Rates Below the MPLs in Measurement Year 2022** ♦ *Cervical Cancer Screening* ♦ *Controlling High Blood Pressure—Total* ♦ *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* ♦ *Lead Screening in Children* ♦ *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* In 2023, AAH used a three-prong approach to improve performance on MCAS measures, focusing on member and provider outreach, education, incentives, and data analytics. **Member Focus** ♦ **Outreach Calls:** Partnered with First 5 Alameda and engaged vendors to conduct outreach, educate members about preventive screenings, and help with scheduling. ♦ **Mailers:** Sent reminders to members to encourage them to schedule well-child visits and cervical cancer screenings. ♦ **Incentives:** Collaborated with providers to address care gaps for measures with rates below the MPLs, offering incentives to motivate members to complete necessary screenings. **Provider Focus** ♦ **Provider Education:** In 2023, conducted webinars and one-on-one meetings, and provided tools to educate providers on HEDIS specifications, correct coding practices, and best practices to improve MCAS measure rates. ♦ **Provider Incentive:** Included MCAS measures with rates below the MPLs in measurement year 2022 in the MCP's P4P program. Additionally,

2022–23 External Quality Review Recommendations Directed to AAH	Actions Taken by AAH to Address the External Quality Review Recommendations
	provided funding to delegated provider groups to improve performance in these areas. For example, AAH provided funding to Community Health Center Network to improve *Controlling High Blood Pressure—Total* measure rates, resulting in a 4.92 percentage point improvement from measurement year 2022 to measurement year 2023. To further enhance MCAS measure rates, AAH offered incentives to improve access to care and provided clinic staff incentives to engage in quality improvement efforts. **Data Analytics** ♦ **Supplemental Data:** Collaborated with providers to collect supplemental data to capture well-child visits recorded under the mother's medical record. ♦ **Other Primary Insurance:** Per HEDIS measure specifications, excluded from measure denominators members who had other primary insurance with extended coverage beyond the allowable care gaps. ♦ **Care Gap Reports:** Shared and reviewed actionable care gap reports with providers. **Results** As a result of the quality improvement efforts, the rates for all but the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure improved from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023. While the rate for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure did not meet or exceed the MPL in measurement year 2023, the rate improved by 5.66 percentage points from measurement year 2022.

Assessment of AAH's Self-Reported Actions

HSAG reviewed AAH's self-reported actions in Table C.1 and determined that AAH adequately addressed the 2022–23 EQR recommendations.

AAH indicated that to resolve the findings from DHCS' compliance review, the MCP:

- Updated policies and procedures.
- Implemented additional monitoring and oversight processes.
- Conducted staff training for processes related to areas in which DHCS identified findings.

AAH noted that DHCS issued official CAP closure notification for the 2023 DHCS Medical Audit.

AAH reported focusing on member and provider outreach, education, incentives, and data analytics to improve performance on measures for which the MCP performed below the MPLs in measurement year 2022. Interventions included:

- Member-Focused
  - Partnered with external organizations to conduct member outreach and education and help members schedule needed preventive appointments.
  - Sent reminders to members to encourage them to schedule well-child visits and cervical cancer screenings.
  - Offered member incentives to motivate members to complete necessary screenings.
- Provider-Focused
  - Conducted provider education and provided tools to providers to help improve performance measure rates.
  - Included performance measures with rates below the MPLs in measurement year 2022 in the MCP's P4P program.
- Data Analytics-Focused
  - Collaborated with providers to collect supplemental data to improve well-child visit rates.
  - Ensured accurate member exclusions from measure denominators.
  - Shared and reviewed care gap reports with providers.

The interventions AAH implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023:

- *Cervical Cancer Screening*
- *Controlling High Blood Pressure—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for AAH

Based on the overall assessment of AAH's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of AAH's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to AAH's 2023 and 2024 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of each PIP.
- The HSAG auditor determined that AAH followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- AAH performed above the HPLs in measurement year 2023 for the following three measure rates that HSAG compared to benchmarks:
  - *Childhood Immunization Status—Combination 10*
  - *Immunizations for Adolescents—Combination 2*
  - *Prenatal and Postpartum Care—Postpartum Care*
- AAH reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for AAH show that the MCP was fully compliant with seven of the 14 CFR standards.
- During the NAV audit process, HSAG noted that AAH conducted ongoing validation and oversight to ensure accuracy and completeness in the provider data collected and maintained in the Provider Repository and HealthSuite database management systems. Additionally, HSAG identified no specific opportunities for improvement related to AAH's data collection and management processes used to inform network adequacy standard and indicator calculations.

Opportunities for Improvement

- AAH performed below the MPLs in measurement year 2023 for the following three of 18 measure rates that HSAG compared to benchmarks (17 percent):
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Lead Screening in Children*
  - *Topical Fluoride for Children—Dental or Oral Health Services—Total*
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for AAH:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Confidentiality—§438.224
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Enrollee Rights—§438.100

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- For measures for which AAH performed below the MPLs in measurement year 2023, identify the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, AAH should determine whether the member-, provider-, and data analytic-focused interventions described in Table C.1 need to be revised or abandoned based on intervention evaluation results.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure AAH meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Confidentiality—§438.224
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Enrollee Rights—§438.100

AAH's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of AAH as well as the plan's progress with addressing these recommendations.

Anthem Blue Cross Partnership Plan

Follow-Up on Prior Year Recommendations

Table C.2 provides the 2022–23 EQR recommendations HSAG made to Anthem Blue Cross, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.2 to preserve the accuracy of Anthem Blue Cross' self-reported actions.

Table C.2—Anthem Blue Cross' Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to Anthem Blue Cross	Actions Taken by Anthem Blue Cross to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Anthem Blue Cross meets all CFR standard requirements moving forward.	§438.206: Anthem Blue Cross updated the MCP's Enforcement Playbook to fully document enforcement actions taken, including CAPs on noncompliant providers. Additionally, DHCS approved Anthem Blue Cross' updated policy and procedure documenting oversight of noncompliant providers. §438.207: Anthem Blue Cross engages in an extensive process with DHCS for the annual network certification (ANC). This includes the submission of an alternative access standards (AAS) request for any time or distance network gaps, which contains our contracting efforts with the two closest out-of-network providers. In addition, there is a validation process whereby Anthem Blue Cross provides contract signature pages for contracted providers. During the remediation process, Anthem Blue Cross works closely with DHCS to address any access issues, providing frequent updates of our efforts to remediate issues. Anthem Blue Cross received DHCS approval on February 7, 2024.

2022–23 External Quality Review Recommendations Directed to Anthem Blue Cross	Actions Taken by Anthem Blue Cross to Address the External Quality Review Recommendations
	§438.228: Anthem Blue Cross now uses a grievances and appeals monitoring dashboard to monitor and ensure timely acknowledgement and timely resolution letters. This dashboard allows managers to monitor inventory in real time and adjust workloads as necessary. In addition to hosting quarterly review sessions with the call center and grievances and appeals teams, Anthem Blue Cross completed internal training to ensure all business areas can identify an appeal or grievance and can properly and in a timely manner route requests to the grievances and appeals department to ensure timely acknowledgement and resolution. Should an appeal or grievance not be fully resolved in a timely manner, Anthem Blue Cross implemented a new systematically generated letter to advise members of the appeal/grievance status and provide a new estimated resolution date.
2. For measures for which Anthem Blue Cross performed below the MPLs in the measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Anthem Blue Cross should determine whether the MCP's member- and provider-focused interventions need to be revised or abandoned based on intervention evaluation results.	In 2022–23, Anthem Blue Cross contracted with the vendor Cozeva to provide to clinics a user-friendly data interface that identifies needed quality care metrics. This tool facilitates timely member-specific information to assist clinicians with identifying services required to meet compliance with HEDIS measures. Provider user engagement expanded to 525,541 members in Cozeva, and 84 providers have been onboarded so far. This intervention is part of a long-term strategy and was revised based on data, to include additional support to capture the data. Anthem Blue Cross:

2022–23 External Quality Review Recommendations Directed to Anthem Blue Cross	Actions Taken by Anthem Blue Cross to Address the External Quality Review Recommendations
	♦ Increased year-round medical record database retrieval for the following measures: ■ *Blood Pressure Control for Patients With Diabetes* ■ *Breast Cancer Screening—Total* ■ *Cervical Cancer Screening* ■ *Child and Adolescent Well-Care Visits*—Total ■ *Childhood Immunization Status—Combination 10* ■ *Chlamydia Screening in Women—Total* ■ *Colorectal Cancer Screening* ■ *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* ♦ Implemented independent physician association (IPA)/physician medical group quarterly meetings with Anthem Blue Cross leadership to discuss HEDIS rates and new DHCS All Plan Letters (APLs) and identify opportunities for improvement. ♦ Implemented a PCP visits and incentive program. ♦ Implemented member outreach activities and the Healthy Rewards member incentive.

Assessment of Anthem Blue Cross' Self-Reported Actions

HSAG reviewed Anthem Blue Cross' self-reported actions in Table C.2 and determined that Anthem Blue Cross adequately addressed the 2022–23 EQR recommendations. Anthem Blue Cross described the steps the MCP took to address the findings from DHCS' most recent compliance review scoring process, including:

- Updated the policy and procedure regarding the MCP's oversight of noncompliant providers.
- Worked with DHCS to fully resolve issues identified during the annual ANC process.

- Implemented a grievances and appeals monitoring dashboard to monitor and ensure timely acknowledgement of grievances and appeals and that resolution letters are sent in the required time frame.

Anthem Blue Cross reported implementing member- and provider-focused interventions to improve performance on measures for which the MCP performed below the MPLs in measurement year 2022, including:

- Partnered with a vendor to provide clinics with a user-friendly data interface that identifies needed quality care metrics.
- Implemented quarterly meetings with providers to discuss performance measure rates and DHCS APLs and identify opportunities for improvement.
- Implemented member outreach and incentive programs.

The interventions Anthem Blue Cross implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023:

- *Breast Cancer Screening—Total* for San Francisco County
- *Child and Adolescent Well-Care Visits—Total* for Tulare County
- *Childhood Immunization Status—Combination 10* for Tulare County
- *Controlling High Blood Pressure—Total* for Fresno County, Madera County, and San Francisco County
- *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for San Francisco County
- *Immunizations for Adolescents—Combination 2* for Contra Costa County
- *Lead Screening in Children* for Madera County and Tulare County

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Anthem Blue Cross

Based on the overall assessment of Anthem Blue Cross' delivery quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Anthem Blue Cross' activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned a *High Confidence* level to Anthem Blue Cross' 2023 and 2024 clinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of its clinical PIP.
- The HSAG auditor determined that Anthem Blue Cross followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- Anthem Blue Cross performed above the HPLs for the following measures in measurement year 2023:
  - *Asthma Medication Ratio—Total* for San Benito County
  - *Chlamydia Screening in Women—Total* for Alameda County and Tulare County
  - *Controlling High Blood Pressure—Total* for San Benito County and Tulare County
  - *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for San Benito County
  - *Immunizations for Adolescents—Combination 2* for Madera County
  - *Prenatal and Postpartum Care—Postpartum Care* for Alameda County, Contra Costa County, Region 1, and San Francisco County
- Based on its performance measure results across all reporting units, Anthem Blue Cross performed better in Tulare and Madera counties, where the MCP met or exceeded the MPLs for 13 and 12 performance measure rates, respectively.
- Anthem Blue Cross reported how the MCP addressed findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for Anthem Blue Cross show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, HSAG noted that Anthem Blue Cross:
  - Maintained staff dedicated to ongoing member and provider data quality assurance, supporting the overall accuracy of network adequacy monitoring.
  - Conducted gap analysis and closed gaps in provider data quality as a result of the plan's legacy system migration in 2023.
  - Conducted regular ongoing internal performance review of network adequacy reports to assess performance and close network adequacy gaps.

Opportunities for Improvement

- HSAG's 2024 PIP validation determined that Anthem Blue Cross failed to include all required details of its PIP processes for its nonclinical PIP.
- Across all reporting units in measurement year 2023, Anthem Blue Cross performed below the MPLs for 130 of the 216 measure rates that HSAG compared to benchmarks (60 percent).

- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for Anthem Blue Cross:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
- During the NAV audit process, Anthem Blue Cross indicated that it used Quest for ongoing monitoring and reporting of time/distance standards while DHCS used ArcGIS. Member addresses that could not be geocoded were excluded from time/distance indicator calculation according to guidance communicated from DHCS. This methodology may differ from identified DHCS logic using representative population points for time/distance indicator calculations.

2023–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure Anthem Blue Cross includes all required information in the MCP's 2025 annual nonclinical PIP submission.
- Based on the audited performance measure rates changing from reporting unit level in measurement year 2023 to plan level in measurement year 2024, and the counties in which the MCP operates changing as of January 1, 2024, Anthem Blue Cross should assess measurement year 2023 performance to determine priority areas for improvement. The MCP should continue implementing interventions that have resulted in positive outcomes and identify new quality improvement strategies as applicable to address factors affecting performance.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure Anthem Blue Cross meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
- Continue to work with DHCS to ensure alignment in network adequacy indicator calculation logic and methodology for network adequacy monitoring.

Anthem Blue Cross' responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of Anthem Blue Cross as well as the plan's progress with addressing these recommendations.

Blue Shield of California Promise Health Plan

Follow-Up on Prior Year Recommendations

Table C.3 provides the 2022–23 EQR recommendations directed to Blue Shield Promise, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.3 to preserve the accuracy of Blue Shield Promise's self-reported actions.

Table C.3—Blue Shield Promise's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to Blue Shield Promise	Actions Taken by Blue Shield Promise to Address the External Quality Review Recommendations
1. For measures for which Blue Shield Promise performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Blue Shield Promise should determine whether the MCP's member- and provider-focused interventions need to be revised or abandoned based on intervention evaluation results.	In measurement year 2022, Blue Shield Promise performed below the MPLs for the *Child and Adolescent Well-Care Visits—Total*, *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*, *Immunizations for Adolescents—Combination 2*, *Cervical Cancer Screening*, and *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measures. In 2023, Blue Shield Promise made changes to enhance existing programs and implemented new programs to address performance in these measures. Blue Shield Promise made changes to the existing member incentive program and increased member incentive amounts for target measures in 2023. This increase was implemented to further influence members to seek preventive care throughout 2023. Additionally, in 2023, Blue Shield Promise worked to support providers with their physician shortages by providing temporary funding for mid-level practitioners who could complete specific preventive care visit types. Throughout 2023, these mid-level practitioners were placed at several groups across the county to increase network bandwidth for all well-child and well-women visits.

2022–23 External Quality Review Recommendations Directed to Blue Shield Promise	Actions Taken by Blue Shield Promise to Address the External Quality Review Recommendations
	In 2023, a strategic approach was developed and implemented for pediatric members who had not been engaged with their PCP in 12 or more months. These members offered well-child visits administered by a community provider and then were redirected back to their PCP to reestablish care. Members were seen via telehealth, in-home, and during clinic days established at various community center. Throughout 2023, Blue Shield Promise partnered with all provider groups to create and implement measure-specific strategies. These strategies were created on a provider-by-provider basis to ensure they could fit within provider workflows and priorities. This work is completed on an ongoing basis and changes based on providers' and members' needs. Cervical cancer screening continues to be a topic of focus during these collaborative efforts as we work toward various strategies to impact the *Cervical Cancer Screening* measure. Our provider incentive programs continued in 2023, with slight modifications to focus on specific measures. The quarterly incentive program started earlier in Quarter 2 (Q2) 2023, instead of Q3 2023, resulting in increased provider engagement across the county. To support improvement for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure, Blue Shield Promise implemented strategies focused on the factors that impact the timeliness of data to identify the eligible population, as well as timely access to appropriate follow-up visits. To access timely data to identify the eligible population, Blue Shield Promise started employing ADT data, which include member and visit information from facilities and providers through HIEs. Leveraging these daily reports enabled Blue

2022–23 External Quality Review Recommendations Directed to Blue Shield Promise	Actions Taken by Blue Shield Promise to Address the External Quality Review Recommendations
	Shield Promise to quickly identify members who had an emergency department visit for mental illness or substance use and who were discharged to home or left against medical advice. Prior to using ADT reports, Blue Shield Promise had to directly access and review different HIE's or wait for the emergency department claim to be processed. Leveraging the ADT reports has decreased the amount of time to receive the necessary information to identify eligible members for outreach. Blue Shield Promise increased access to appropriate follow-up visits for members seen in the emergency department by partnering with a mid-level practitioner group with mental health and substance use clinical experience and expertise. These providers have been able to conduct live outreach to members within 24 hours of being notified the member had an applicable emergency department visit and was discharged from the facility. These mid-level practitioners then follow up with the member, employ age-appropriate and standardized screening tools, make appropriate referrals, and notify the member's PCP about the follow-up visit.

Assessment of Blue Shield Promise's Self-Reported Actions

HSAG reviewed Blue Shield Promise's self-reported actions in Table C.3 and determined that Blue Shield Promise adequately addressed the 2022–23 EQR recommendations.

Blue Shield Promise reported implementing member- and provider-focused interventions to improve performance on measures for which the MCP performed below the MPLs in measurement year 2022, including:

- Implemented changes to the MCP's member incentive program, including increasing member incentive amounts.
- Provided temporary funding for staffing at provider groups to increase capacity for completing well-child and well-women visits.
- Implemented a process to allow for easier access to well-child visits for members who had not seen their PCPs in 12 or more months.

- Partnered with provider groups to create and implement measure-specific strategies.
- Implemented changes to the MCP's provider incentive programs to focus on specific measures.
- Implemented strategies to improve data availability for identifying the eligible population for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure.
- Increased access to follow-up visits for members with substance use and other mental health disorders who are seen in the emergency department.

The interventions Blue Shield Promise implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023:

- *Child and Adolescent Well-Care Visits—Total*
- *Immunizations for Adolescents—Combination 2*

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Blue Shield Promise

Based on the overall assessment of Blue Shield Promise's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Blue Shield Promise's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to Blue Shield Promise's 2023 and 2024 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of each PIP.
- The HSAG auditor determined that Blue Shield Promise followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- DHCS' 2024 compliance review scores for Blue Shield Promise show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, HSAG identified no specific opportunities for improvement related to Blue Shield Promise's data collection and management processes used to inform network adequacy standard and indicator calculations and noted the following:

- Blue Shield Promise demonstrated its capability of maintaining an adequate provider network to service members which included comprehensive contracting, provider data maintenance, and monitoring and reporting methods. Blue Shield Promise addressed any gaps in the network by submitting exception requests to DHCS and increasing contracting efforts to fill network gaps.
- Blue Shield Promise's Provider Operations department launched an improved provider portal and included additional capabilities whereby providers can log in and attest and/or update their directory data in real time, with the majority of the updates displayed in the online provider directory within 48 hours. The implementation of the improved provider portal greatly increased the timeliness and quality of Blue Shield Promise's network data.
- Blue Shield Promise maintained a very detailed, comprehensive process for documenting, capturing, and reporting network adequacy results, and ensured business continuity of the network adequacy monitoring and reporting process.

Opportunities for Improvement

- Blue Shield Promise performed below the MPLs in measurement year 2023 for the following five of 18 measure rates that HSAG compared to benchmarks (28 percent):
  - *Cervical Cancer Screening*
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
  - *Topical Fluoride for Children—Dental or Oral Health Services—Total*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for Blue Shield Promise:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Grievance and Appeal Systems—§438.228

2023–24 External Quality Review Recommendations

- For measures for which Blue Shield Promise performed below the MPLs in measurement year 2023, identify the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Blue Shield Promise should determine whether the member- and provider-focused interventions described in Table C.3 need to be revised or abandoned based on intervention evaluation results.

- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure Blue Shield Promise meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Grievance and Appeal Systems—§438.228

Blue Shield Promise's response to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of Blue Shield Promise as well as the plan's progress with addressing these recommendations.

California Health & Wellness Plan

Follow-Up on Prior Year Recommendations

CHW's contract with DHCS ended December 31, 2023; therefore, HSAG made no 2022–23 EQR recommendations to the plan since CHW was not under contract with DHCS in July 2024 when HSAG requested summaries of how plans addressed the 2022–23 EQR recommendations.

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CHW

While CHW's contract with DHCS ended December 31, 2023, DHCS required the plan to participate in the measurement year 2023 PMV, compliance review scoring, and validation of network adequacy audit processes. HSAG therefore identified strengths and opportunities for improvement based on the results of these activities; however, because CHW is no longer under contract with DHCS, HSAG makes no recommendations to the plan.

Based on the overall assessment of CHW's delivery of quality, timely, and accessible care through the 2023–24 EQR activities in which the plan participated, HSAG identified the following strengths and opportunities for improvement. Note that all of CHW's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- For all measures except the long-term care (LTC) measures, the HSAG auditor determined that CHW followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- CHW performed above the HPLs for the following measures in measurement year 2023:
  - *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for Imperial County
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Region 1
- Based on its performance measure results, CHW performed better in Imperial County, where it met or exceeded the MPLs for 10 performance measure rates compared to four rates each for Region 1 and Region 2.
- DHCS' 2024 compliance review scores for CHW show that the MCP was fully compliant with all but one of the 14 CFR standards.

- During the NAV audit process, HSAG identified no specific opportunities for improvement related to CHW's data collection and management processes used to inform network adequacy standard and indicator calculations. During the audit, CHW demonstrated the capability of:
  - Ensuring the accuracy of its provider network by conducting rigorous quality assurance measures which included regular outreach to providers to attest provider data and regular validation checks of provider data.
  - Ensuring the accuracy of network adequacy indicator calculation and reporting metrics by conducting several multi-staffed quality assurance methods to verify accuracy of data.
  - Maintaining an adequate provider network to service its members which included comprehensive contracting, provider data maintenance, and monitoring and reporting methods. CHW addressed gaps in its network by submitting AAS requests to DHCS and increasing contracting efforts to fill network gaps.

Opportunities for Improvement

- Due to data issues, CHW was unable to calculate any LTC measure rates.
- Across all reporting units in measurement year 2023, CHW performed below the MPLs for 36 of the 54 measure rates that HSAG compared to benchmarks (67 percent).
- DHCS identified findings within the Grievance and Appeal Systems CFR standard (§438.228) during the DHCS 2024 compliance review scoring process for CHW.

2023–24 External Quality Review Recommendations

CHW's contract with DHCS ended December 31, 2023; therefore, HSAG makes no recommendations to the MCP since CHW will not be under contract with DHCS in July 2025 when HSAG requests summaries of how MCPs addressed the 2023–24 EQR recommendations.

CalOptima

Follow-Up on Prior Year Recommendations

Table C.4 provides the 2022–23 EQR recommendations directed to CalOptima, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.4 to preserve the accuracy of CalOptima's self-reported actions.

Table C.4—CalOptima's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to CalOptima	Actions Taken by CalOptima to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure CalOptima meets all CFR standard requirements moving forward.	CalOptima has worked with DHCS to resolve its findings from the DHCS compliance review to meet CFR requirement §438.208: Coordination and Continuity of Care. The plan implemented actions to 1) ensure that an initial health appointment (IHA) was performed by the member's PCP, perinatal care providers, and non-physician mid-level practitioners; and 2) ensure that members who did not have medical utilization data, claims processing data history, or other assessments or survey information available for the Pediatric Risk Stratification Process were automatically categorized as high risk until further assessment data were gathered to make an additional risk determination. Actions implemented by CalOptima for Finding #1 included the following: ♦ Updated internal policies to align with DHCS APL 22-024: Population Health Management Policy Guide and clarified expectations of providers and delegated health networks. ♦ Updated internal systems to only include a member's PCP, perinatal care provider, or non-physician mid-level practitioner in the IHA reporting. ♦ Conducted monthly monitoring to ensure the IHA is only being completed by the member's PCP,

2022–23 External Quality Review Recommendations Directed to CalOptima	Actions Taken by CalOptima to Address the External Quality Review Recommendations
	perinatal care provider, or a non-physician mid-level practitioner. ♦ Provided the IHA performance reports to the Quality Improvement and Health Equity Committee (QIHEC) quarterly. ♦ Conducted training of CalOptima providers and delegated health networks to increase awareness of IHA requirements. Actions implemented by CalOptima for Finding #2 included the following: ♦ Updated technical specifications for the Whole Child Model (WCM) Pediatric Risk Stratification to reflect regulatory requirements. ♦ Presented the updated WCM Pediatric Risk Stratification to the QIHEC. ♦ Implemented quarterly internal auditing to ensure compliance with the regulatory process of the WCM Pediatric Risk Stratification; the monitoring is to confirm the logic implementation and accuracy of the risk determination. On December 29, 2023, DHCS notified CalOptima that DHCS had accepted and closed CalOptima's CAP.
2. Assess the factors that contributed to CalOptima performing below the MPL in measurement year 2022 for the *Lead Screening in Children* measure and implement quality improvement strategies that target the identified factors.	CalOptima has assessed the factors that contributed to the MCP's performance below the MPL. CalOptima determined that it did not have adequate oversight and did not interpret the requirements accurately. CalOptima has worked with DHCS to resolve its findings from the 2022 DHCS Medical Audit. The MCP implemented actions to 1) ensure the provision of oral or written anticipatory guidance by its network providers to the parents or guardians of child members ages 6 months and continuing until 72 months; and 2) ensure the provision of blood lead screening tests to child members at 12 months and

2022–23 External Quality Review Recommendations Directed to CalOptima	Actions Taken by CalOptima to Address the External Quality Review Recommendations
	24 months of age, and up to 72 months when there were no documented blood lead screenings. Actions implemented by CalOptima included: ♦ Used the DHCS Medical Record Review Tool issued in July 2022 during the facility site review process to assess for the requirements. ♦ Developed an attestation process to ensure the delegated health networks are reviewing reports that identify members who have not tested for lead in accordance with state-issued guidelines. ♦ Ensured that providers are testing and abiding by anticipatory guidance requirements. ♦ Implemented various provider and member education efforts to increase blood lead testing rates. On August 10, 2023, DHCS notified CalOptima that DHCS had accepted and closed CalOptima's CAP.

Assessment of CalOptima's Self-Reported Actions

HSAG reviewed CalOptima's self-reported actions in Table C.4 and determined that CalOptima adequately addressed the 2022–23 EQR recommendations.

CalOptima indicated that the MCP worked with DHCS to resolve the findings from DHCS' compliance review related to the Coordination and Continuity of Care standard. CalOptima stated that to address the findings, the MCP updated policies and procedures and implemented monitoring processes.

CalOptima reported that from its assessment of the factors contributing to the MCP's performance below the MPL for the *Lead Screening in Children* measure in measurement year 2022, CalOptima determined that it did not have adequate oversight and had not interpreted the blood lead screening requirements accurately. CalOptima stated that the identified factors were reflected in the findings from the 2022 DHCS Medical Audit and indicated that the MCP worked with DHCS to fully resolve the findings. CalOptima implemented internal and external processes and conducted provider and member education to improve blood lead testing rates. These strategies may have contributed to the rate for the *Lead Screening in Children* measure

moving from below the MPL in measurement year 2022 to above the MPL in measurement year 2023.

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CalOptima

Based on the overall assessment of CalOptima's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of CalOptima's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to CalOptima's 2023 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in the Design stage of each PIP.
- The HSAG auditor determined that CalOptima followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- CalOptima performed above the HPLs in measurement year 2023 for the following three measure rates that HSAG compared to benchmarks:
  - *Chlamydia Screening in Women—Total*
  - *Controlling High Blood Pressure—Total*
  - *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
- CalOptima reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for CalOptima show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, HSAG noted that CalOptima:
  - Had a well-defined process in place for collecting and maintaining both provider and member data in the Facets system.
  - Had a comprehensive oversight process for maintaining accurate provider information received from the health networks.

- Maintained detailed process documentation for analyst creation of the network adequacy report, ensuring business continuity of the network adequacy monitoring and reporting process.

Opportunities for Improvement

- HSAG's 2024 PIP validation determined that CalOptima failed to include all required details of its PIP processes for both clinical and nonclinical PIPs.
- CalOptima performed below the MPLs in measurement year 2023 for the following two of 18 measure rates that HSAG compared to benchmarks (11 percent):
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for CalOptima:
  - Availability of Services—§438.206
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Enrollee Rights—§438.100
- During the NAV audit process, HSAG noted that although CalOptima was conducting monitoring and oversight, the MCP indicated challenges in aligning methodologies for calculation of network adequacy indicators to DHCS-published methodologies.

2023–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure CalOptima includes all required information in the MCP's 2025 annual clinical and nonclinical PIP submissions.
- For measures for which CalOptima performed below the MPLs in measurement year 2023, identify the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure CalOptima meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Enrollee Rights—§438.100
- Evaluate the DHCS ANC APL and outreach to DHCS to ensure CalOptima has a clear understanding of DHCS' expectations for calculating network adequacy indicators.

CalOptima's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of CalOptima as well as the plan's progress with addressing these recommendations.

CalViva Health

Follow-Up on Prior Year Recommendations

Table C.5 provides the 2022–23 EQR recommendations directed to CalViva, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.5 to preserve the accuracy of CalViva's self-reported actions.

Table C.5—CalViva's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to CalViva	Actions Taken by CalViva to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure CalViva meets all CFR standard requirements moving forward.	DHCS identified that CalViva did not classify, process, review, or resolve all expressions of dissatisfaction as grievances. In response to the DHCS CAP for this issue, CalViva implemented the following: ♦ The member services call center leadership hosted several training sessions with customer service advocates (CSAs) to review how to identify grievances using defined criteria that distinguish inquiries from grievances. Also, in support of CSA training, the MCP also instituted a type of "secret shopper" approach that provides CSAs with various member call scenarios and how to identify them as either inquiries, grievances, or appeals, and the correct turnaround time for MCP response. ♦ Monthly, a quality analyst audits a randomized sample of inquiry calls made to the member services phone number. The analyst uses a worksheet tool to check if there was a clear or implied expression of dissatisfaction and, if so, whether it was properly routed to the appeals and grievances department for processing. ♦ CalViva also revised policies and desktop procedures to clarify the proper process for reviewing and auditing calls, and describing the process for corrective actions once the

2022–23 External Quality Review Recommendations Directed to CalViva	Actions Taken by CalViva to Address the External Quality Review Recommendations
	audit results determine there is noncompliance. ♦ The results of the audit are reported quarterly to CalViva's appeals and grievances workgroup to track and trend issues and document opportunities to improve processes or policies when necessary. In response to CalViva's corrective actions, DHCS closed the CAP on April 19, 2024.
2. For measures for which CalViva performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. a. Based on measurement year 2022 performance measure results, CalViva should prioritize implementing quality improvement strategies in Fresno and Kings counties.	To address underperforming measures, particularly for Fresno and Kings counties, CalViva implemented regulatory and additional initiatives to drive improvements, including but not limited to the following: ♦ To address childhood immunizations, breast cancer screenings, well-child visits, and behavioral health measures, CalViva completed or started the following required regulatory performance improvement activities: ■ The *Breast Cancer Screening* Health Equity PIP exceeded its goal for improving mammogram completion rates for the Southeast Asian population in Fresno County through the use of mobile mammography events with on-site education and culturally appropriate incentives. ■ The *Childhood Immunizations* PIP exceeded its goal. Two interventions successfully improved immunization rates at the targeted clinic in Fresno County. The first intervention was including hepatitis B immunizations given at birth in the clinic immunization records, and the second intervention was hosting "Heroes for Health Immunization" weekend events at the clinic with outreach and member incentives.

2022–23 External Quality Review Recommendations Directed to CalViva	Actions Taken by CalViva to Address the External Quality Review Recommendations
	■ CalViva developed a SWOT (Strengths, Weaknesses, Opportunities, Threats) project for Fresno County, and DHCS approved the project on November 30, 2023. Well-care visits and childhood immunization measures were targeted for these improvement activities. Strategies were implemented, including retrieving the hepatitis B data from hospitals; converting sick to well-care visits, which led to the offering of expanded hours dedicated to well-care visits; and immunizing children at any visit. ■ CalViva initiated a new clinical PIP to focus on improving well-child visits among Black or African American infants in Fresno County. CalViva submitted project steps 1 through 6 to HSAG in Q3 2023 and received a final validation score of 100 percent. The first intervention is currently being tested and involves collaboration with the Black Infant Health Program from the California Department of Public Health (CDPH). All Black/African American members who are pregnant or who have delivered in the last three months are being referred to the Black Infant Health Program for outreach and engagement, as well as follow-up with an emphasis on well-child visits and immunizations. Initial results are pending. ■ CalViva initiated a new nonclinical PIP to address follow-up after an emergency department visit for substance use or mental health in Fresno and Madera counties. CalViva submitted project steps 1 through 6 in Q4 2023 and received a final validation score of 100 percent. CalViva will test two interventions. The first intervention includes education and tools for designated hospital staff on the use of codes to close care gaps. The second

2022–23 External Quality Review Recommendations Directed to CalViva	Actions Taken by CalViva to Address the External Quality Review Recommendations
	intervention provides culturally appropriate education, resources, and referrals to a community-based organization to increase completion of follow-up care for the Hispanic population. Initial results are pending. ■ CalViva is participating in an Institute for Healthcare Improvement Health Equity Collaborative sponsored by DHCS to improve well-care visits. In partnership with a local FQHC in Fresno County, the team is focused on improving compliance with well-child visits for Hispanic children ages 0 to 15 months. ■ CalViva initiated two lean health equity projects in April 2024: ○ To improve follow-up for substance use/mental health issues in Madera County. ○ To improve well-child visits, immunizations, and other childhood measures in Kings County. ■ CalViva initiated a comprehensive improvement project for Fresno County in April 2024 to improve measures in the Children's Health and Behavioral Health domains. ♦ CalViva implemented the following quality improvement initiatives for additional performance measures: ■ Partnered with Fresno County Department of Public Health's Lead Poisoning Prevention Program to provide training to high-volume lead screening providers in Fresno County. Provider engagement teams worked with pediatric providers to improve best practices and provided lead screening education to these providers. ■ Provided funding support to providers and groups for activities to close care gaps. Activities included member outreach call

2022–23 External Quality Review Recommendations Directed to CalViva	Actions Taken by CalViva to Address the External Quality Review Recommendations
	campaigns, equipment for providers, educational materials, lead screening resources, technology support, direct care services (one-stops and mobile mammography), and member and provider incentives. ■ Partnered with Central California Asthma Collaborative and implemented an asthma home visitation program that included education and environmental trigger mitigation. The program included assessing members' understanding of asthma, conducting a home environmental assessment, discussing trigger reduction, and reviewing proper use of medications. ■ Prioritized three high-volume, low-performing providers to monitor and incentivize clinical measure improvement initiatives.

Assessment of CalViva's Self-Reported Actions

HSAG reviewed CalViva's self-reported actions in Table C.5 and determined that CalViva adequately addressed the 2022–23 EQR recommendations.

CalViva indicated that to resolve the findings from DHCS' compliance review related to member expression of dissatisfaction, the MCP revised policies and procedures. In response to CalViva's corrective actions, DHCS closed the CAP.

CalViva described the provider- and member-focused interventions and strategies the MCP implemented to improve performance on measures for which the MCP performed below the MPLs in measurement year 2022, with most efforts targeting Fresno and Kings counties. CalViva reported conducting PIPs to address the MCP's performance on select measures, partnering with external organizations to improve access to health care services for members, conducting provider and member education, and offering culturally appropriate member incentives.

The interventions and strategies CalViva implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023 for Fresno County:

- *Cervical Cancer Screening*
- *Child and Adolescent Well-Care Visits—Total*

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CalViva

Based on the overall assessment of CalViva's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of CalViva's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to CalViva's 2023 and 2024 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of each PIP.
- The HSAG auditor determined that CalViva followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- CalViva performed above the HPLs for the following measures in measurement year 2023:
  - *Breast Cancer Screening—Total* for Madera County
  - *Cervical Cancer Screening* for Madera County
  - *Child and Adolescent Well-Care Visits—Total* for Madera County
  - *Childhood Immunization Status—Combination 10* for Madera County
  - *Controlling High Blood Pressure—Total* for Kings County
  - *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for Kings County
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Kings County
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* for Madera County
- Based on its performance measure results, CalViva performed better in Madera County, where it met or exceeded the MPLs for 16 performance measure rates compared to nine rates and seven rates for Fresno County and Kings County, respectively.

- CalViva reported fully addressing the finding from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for CalViva show that the MCP was fully compliant with all but one of the 14 CFR standards.
- During the NAV audit process, HSAG noted that CalViva had a well-defined process in place for oversight of its delegated entities.

Opportunities for Improvement

- Across all reporting units in measurement year 2023, CalViva performed below the MPLs for 22 of the 54 measure rates that HSAG compared to benchmarks (41 percent).
- DHCS identified findings within the Coverage and Authorization of Services CFR standard (§438.210) during the DHCS 2024 compliance review scoring process for CalViva.
- During the NAV audit process, CalViva reported challenges with internal monitoring of provider ratios due to uncertainty in guidelines of expected methodologies to be used. In addition, CalViva used a methodology,100 Points of Light, for calculation of member addresses as part of internal monitoring. DHCS' guidance through APLs referenced a different methodology used by DHCS for network adequacy calculation.

2023–24 External Quality Review Recommendations

- Based on the audited performance measure rates changing from reporting unit level in measurement year 2023 to plan level in measurement year 2024, CalViva should assess measurement year 2023 performance to determine priority areas for improvement. The MCP should continue implementing interventions that have resulted in positive outcomes and identify new quality improvement strategies as applicable to address factors affecting performance.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the Coverage and Authorization of Services CFR standard (§438.210) to ensure CalViva meets all CFR standard requirements moving forward.
- Work with DHCS to identify and clarify methodologies used by DHCS for calculation of network adequacy indicators, to ensure CalViva's efforts are meeting DHCS' expectations.

CalViva's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of CalViva as well as the plan's progress with addressing these recommendations.

CenCal Health

Follow-Up on Prior Year Recommendations

Table C.6 provides the 2022–23 EQR recommendations directed to CenCal, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.6 to preserve the accuracy of CenCal's self-reported actions.

Table C.6—CenCal's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to CenCal	Actions Taken by CenCal to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure CenCal meets all CFR standard requirements moving forward.	CenCal participated in the 2022–23 encounter data validation (EDV) audit, 2022–23 ANC, and quality improvement compliance assessments by DHCS, and DHCS identified no findings. With no findings identified, CenCal was assigned zero corrective actions as part of those reviews. For the DHCS Medical Audit portion of the compliance review scoring process, CenCal reviewed and addressed all findings contained within the 2022 DHCS Medical Audit Report issued on May 31, 2023, and fully closed all corrective actions on October 13, 2023. DHCS identified nine findings during the Medical Audit, and CenCal immediately formed internal, cross-functional working groups to quickly address gaps and identify how those gaps contributed to findings. CenCal additionally prepared a CAP response that included a complete root cause analysis, CenCal's actions necessary to fully remediate findings, and the appropriate supporting documents that outlined all work to DHCS. Once each finding was fully addressed by CenCal, full remediation was ensured by

2022–23 External Quality Review Recommendations Directed to CenCal	Actions Taken by CenCal to Address the External Quality Review Recommendations
	additionally submitting documentation of internal auditing/continuous monitoring efforts that were put into place to prevent future noncompliance, thus demonstrating effective corrective action implementation. The 2023 DHCS Medical Audit of CenCal reviewed all aspects of the 2022 CAP remediation actions and implementation, and this audit resulted in no findings for CenCal.
2. For measures for which CenCal performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors.	CenCal identified a variety of factors that may have contributed to the MCP performing below the MPLs for five of 30 measure rates that HSAG compared to benchmarks in measurement year 2022: ♦ *Controlling High Blood Pressure—Total* for both reporting units ♦ *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* for Santa Barbara County ♦ *Lead Screening in Children* for both reporting units Below are the quality improvement strategies that were implemented by CenCal based on root cause analyses that targeted the identified factors for each measure. Key strategies included promotion of PCP incentives, practice transformation support activities, and member education/engagement activities. *Controlling High Blood Pressure—Total* A barrier analysis conducted with PCPs and with CenCal internal staff members identified an opportunity to increase member awareness of available benefits (transportation and at-home blood pressure monitoring), as well as engaging in practice transformation support to increase provider knowledge about Current Procedural Terminology (CPT) Category II

2022–23 External Quality Review Recommendations Directed to CenCal	Actions Taken by CenCal to Address the External Quality Review Recommendations
	codes, documentation of blood pressure readings during virtual calls, and CenCal's available benefits for members. Practice Transformation/Education: Through quality collaboratives with CenCal's high-volume PCP practices, CenCal's Quality Department staff members shared measurement year 2022 *Controlling High Blood Pressure* measure rates. On average, telehealth exams were a missed opportunity to collect blood pressure readings from the member. For blood pressure readings collected through virtual appointments, a range was documented in lieu of specific numbers. This is critical for numerator compliance of the measure. Additionally, when blood pressure readings were documented and were greater than 140/90 mmHg, PCP office staff members missed the opportunity to recheck the blood pressure as the measure guidelines allow for the collection of the best systolic and diastolic reading. CenCal's Quality Department staff members led focused trainings with a high-volume clinic system in Q3 2023 to promote the reporting of CPT Category II codes, clarify how blood pressure readings should be documented to align with NCQA HEDIS Technical Specifications, and increase provider awareness of CenCal's transportation and at-home blood pressure monitor benefit. Member Education/Engagement: To increase member knowledge of the importance of regular blood pressure monitoring to control high blood pressure, CenCal launched a member educational campaign in Q3 2023 for members with hypertension who had not yet been seen by

2022–23 External Quality Review Recommendations Directed to CenCal	Actions Taken by CenCal to Address the External Quality Review Recommendations
	their PCP in the measurement year. The member mailing campaign provided information on the importance of routine screening, encouraged members to schedule an appointment with their PCPs, and included a blood pressure diary for members to record blood pressure readings to share with their PCPs at their next appointment. The mailer also provided information on CenCal's transportation and blood pressure monitor benefits. Measurement Year 2023 Results: CenCal addressed barriers to member and provider engagement by implementing provider training and education interventions. Through these efforts, CenCal's *Controlling High Blood Pressure—Total* measure rate improved in Santa Barbara County from 59.35 percent for measurement year 2022 to 62.56 percent for measurement year 2023, and in San Luis Obispo County from 59.02 percent for measurement year 2022 to 63.82 percent for measurement year 2023. For both reporting units, CenCal performed above the MPL (61.31 percent) for measurement year 2023. *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* A factor identified that affected CenCal's performance for this aspect of care includes the lack of an infrastructure for timely notification to PCPs when a member has been seen in the emergency department for substance abuse/mental illness to ensure timely follow-up. CenCal is addressing improvement for this aspect of care through a nonclinical PIP.

2022–23 External Quality Review Recommendations Directed to CenCal	Actions Taken by CenCal to Address the External Quality Review Recommendations
	Provider Engagement: In 2023, CenCal Quality Department staff members promoted CenCal's nonclinical PIP through provider bulletin articles; memo/presentation to its Quality Improvement and Health Equity Committee, comprised of various providers within CenCal's network; and via focused quality collaborative meetings with high-volume PCPs. Through these efforts, CenCal staff members identified the need to implement an emergency department report that notifies PCPs when a member was seen in the emergency department with the appropriate diagnosis codes. PIP Emergency Department Report: CenCal launched an emergency department report, available via the MCP's provider portal, that notifies PCPs if a member was seen in the emergency department for substance abuse or mental illness. The percentage of notifications completed within seven days is largely dependent on timely emergency department claims submission which remains a challenge. Measurement Year 2023 Results: CenCal did not meet the MPL for this aspect of care in either reporting unit. CenCal did not receive timely and complete specialty mental health claims from DHCS, which significantly impacted results for this measurement period. Data incompleteness was a barrier to reporting. *Lead Screening in Children* CenCal Quality Department staff members engaged in PCP interview gathering sessions and identified that not all PCPs or their staff members were aware of screening requirements for children who are on

2022–23 External Quality Review Recommendations Directed to CenCal	Actions Taken by CenCal to Address the External Quality Review Recommendations
	government assistance programs like Medi-Cal. While CenCal launched its PCP incentive program, Quality Care Incentive Program, in March 2022, it was shared by PCPs that some practices had not yet prioritized improvement for this aspect of care. When interviewing high-performing PCPs, CenCal quality staff members identified that providers who performed point-of-care blood lead testing in their offices had higher rates of performance compared to PCP practices that referred patients to laboratories (labs) for blood draws. PCP Incentives/Practice Transformation: Key strategies CenCal implemented to improve this aspect of care included increased promotion of the CenCal PCP incentive program by engaging in monthly quality collaboratives and quarterly Joint Operations Committee meetings with high-volume practices that serve the pediatric population. These meetings started in Q1 2023. Practice transformation support provided during monthly quality collaborative calls that addressed this opportunity for improvement included: ♦ Promotion of the American Academy of Pediatrics Bright Futures Periodicity Schedule and federal requirements. ♦ Monthly review of PCPs' *Lead Screening in Children* measure rates (also available on the provider portal) compared to the pediatric network average and the Medicaid 90th percentile. ♦ Promotion of CenCal's aging Lead Testing Opportunity Report starting in Q2 2024 that identifies children who have not received a lead test by age 1 and age 2, and those due for catch-up through 72 months of age (also available on the provider portal).

2022–23 External Quality Review Recommendations Directed to CenCal	Actions Taken by CenCal to Address the External Quality Review Recommendations
	♦ Quarterly review of PCP financial incentives not earned through the Quality Care Incentive Program. ♦ Promotion of point-of-care testing as a best practice. One large FQHC system that CenCal partnered with credited the significant improvement in rates to the purchasing of lead analyzers for several of its practice locations. MY 2023 Results: Through these strategic interventions and provider engagement, CenCal's PCP network improved *Lead Screening in Children* measure rates in Santa Barbara County from 62.29 percent for measurement year 2022 to 66.67 percent for measurement year 2023, and in San Luis Obispo County from 50.36 percent for measurement year 2022 to 69.34 percent for measurement year 2023. For both reporting units, CenCal performed above the MPL (62.79 percent) for measurement year 2023.

Assessment of CenCal's Self-Reported Actions

HSAG reviewed CenCal's self-reported actions in Table C.6 and determined that CenCal adequately addressed the 2022–23 EQR recommendations. CenCal indicated that all findings from DHCS' most recent compliance review scoring process were from DHCS' Medical Audit of the MCP. CenCal described the steps the MCP took to resolve all findings and reported that DHCS closed all corrective actions on October 13, 2023. Additionally, CenCal noted that during the 2023 DHCS Medical Audit, DHCS reviewed the MCP's implementation of the previous corrective actions and identified no new findings.

CenCal reported implementing member- and provider-focused interventions based on root cause analyses to improve performance on measures for which the MCP performed below the MPLs in measurement year 2022, including:

- Conducted focused provider trainings on identified areas in need of improvement.
- Launched a member education and engagement campaign that provided information on the importance of routine blood pressure screenings, encouraged members to schedule

needed appointments, and provided information on CenCal's transportation and blood pressure monitor benefits.
- Developed a new process for notifying PCPs when their patients with substance use and other mental health disorders are seen in the emergency department.
- Increased promotion of CenCal's PCP blood lead screening incentive program through monthly quality collaboratives and quarterly Joint Operations Committee meetings with high-volume practices that serve the pediatric population.
- Used blood lead screening data to inform providers of opportunities for improvement.

The interventions CenCal implemented may have contributed to the rates for the following measures for both reporting units moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023:

- *Controlling High Blood Pressure—Total*
- *Lead Screening in Children*

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CenCal

Based on the overall assessment of CenCal's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of CenCal's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to CenCal's 2023 and 2024 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of each PIP.
- The HSAG auditor determined that CenCal followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- CenCal performed above the HPLs for the following measures in measurement year 2023:
  - *Asthma Medication Ratio—Total* San Luis Obispo County and Santa Barbara County
  - *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for San Luis Obispo County
  - *Prenatal and Postpartum Care—Postpartum Care* for San Luis Obispo County and Santa Barbara County

  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for San Luis Obispo County
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* for Santa Barbara County
- CenCal reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for CenCal show that the MCP was fully compliant with all CFR standards.
- During the NAV audit process, CenCal demonstrated a comprehensive process for conducting ongoing monitoring and validation of provider information to ensure accurate, complete, and timely updates are captured.

Opportunities for Improvement

- Across both reporting units in measurement year 2023, CenCal performed below the MPLs for the following six of 36 measure rates that HSAG compared to benchmarks (17 percent):
  - *Childhood Immunization Status—Combination 10* for San Luis Obispo County
  - *Developmental Screening in the First Three Years of Life—Total* for San Luis Obispo County
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* for San Luis Obispo County and Santa Barbara County
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* for Santa Barbara County
  - *Immunizations for Adolescents—Combination 2* for San Luis Obispo County
- During the NAV audit process, CenCal reported challenges with internal monitoring of provider ratios due to uncertainty in guidelines of expected methodologies to be used. In addition, CenCal used a methodology, 100 Points of Light, for calculation of member addresses as part of internal monitoring, which was observed to differ from the DHCS APL guidance.

2023–24 External Quality Review Recommendations

- Based on the audited performance measure rates changing from reporting unit level in measurement year 2023 to plan level in measurement year 2024, CenCal should assess measurement year 2023 performance to determine priority areas for improvement. The MCP should continue implementing interventions that have resulted in positive outcomes and identify new quality improvement strategies as applicable to address factors affecting performance.
- Work with DHCS to identify and clarify methodologies used by DHCS for calculation of network adequacy indicators, to ensure CenCal's efforts are meeting DHCS' expectations.

CenCal's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of CenCal as well as the plan's progress with addressing these recommendations.

Central California Alliance for Health

Follow-Up on Prior Year Recommendations

Table C.7 provides the 2022–23 EQR recommendations directed to CCAH, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.7 to preserve the accuracy of CCAH's self-reported actions.

Table C.7—CCAH's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to CCAH	Actions Taken by CCAH to Address the External Quality Review Recommendations
1. For measures for which CCAH performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, CCAH should determine whether the MCP's member- and provider-focused interventions need to be revised or abandoned based on intervention evaluation results.	Merced County residents face greater socio-geographic health challenges as indicated by the Healthy Places Index score when compared to our more coastal communities. All performance measures with measurement year 2022 rates below the MPL were from Merced County, which reflects the health equity differences from CCAH's Monterey/Santa Cruz counties reporting unit. The EQR report highlighted the need to focus on Merced County due to the difference in performance. As part of the MCP's quality strategy, provider and member interventions have continued to be updated to help achieve improvement, particularly in Merced County. <u>Provider Strategies</u> Provider strategies included funding for staffing and equipment as well as establishing communication forums for discussions and best practice sharing. Challenges faced by our practices include hiring and retaining staff. In response, CCAH established a Workforce Support for Care-Gap Closure grant in late 2023 for the largest Merced County providers. In 2024, CCAH expanded the grant to pay for locum providers in Merced County with more than 1,000 linked members. These grant funds for locum providers support expanded hours for after-hours and weekend appointments to help school-age children

2022–23 External Quality Review Recommendations Directed to CCAH	Actions Taken by CCAH to Address the External Quality Review Recommendations
	and working parents access care, focusing on visits specific to services required for MCAS performance measures. The increased visit access supports *Childhood Immunization Status—Combination 10*, *Immunizations for Adolescents—Combination 2*, *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*, *Child and Adolescent Well-Care Visits—Total*, *Lead Screening in Children*, *Breast Cancer Screening—Total*, and *Chlamydia Screening in Women—Total* measures. Additionally, as part of the grant, CCAH provided equipment reimbursement for point-of-care blood lead screenings to help increase access and reduce barriers for members to receive lead screening. In-office lead screening helps reduce the number of visits needed for members to complete required screenings by eliminating the time needed to visit another facility for the lab screening. In addition to the locum grant, CCAH expanded workforce recruitment grants to support community health workers and doulas in addition to medical assistants and providers. Technology grants also offered providers expanded opportunities to communicate with members, including developing texting campaigns for members past due for services, with upcoming appointments, or overdue for specific preventive services (e.g., flu shot, breast cancer screening). CCAH launched a new Provider Partnership Pilot Program with five of our largest provider clinics in Merced County to focus on pediatric well-child visits. The MCP also launched a new forum for Merced County providers to discuss barriers to close care gaps, community culture, and support needed from CCAH. Discussions in the provider forum have led to the request for CCAH to create a women's health and

2022–23 External Quality Review Recommendations Directed to CCAH	Actions Taken by CCAH to Address the External Quality Review Recommendations
	vaccine hesitancy lunch and learn session, which is planned for the fall. CCAH also revised its primary care incentive payment program to include additional payment for performance improvement to support geographically disadvantaged communities in an effort to address disparities present. <u>Member Strategies</u> Strategies to support members in accessing care include direct member incentives as well as increased communication efforts and support for providing more accessible preventive services to members. CCAH began the Healthy Start Program in April 2023 that provides direct incentives (gift cards) for pediatric members for completing immunizations, well-child visits, or well-care visits. CCAH actively promoted this program to members, network providers, community partners, and internal CCAH departments with staff members who interact with members. CCAH promoted the Healthy Start Program online with the MCP's social media platforms and website. Materials were created and distributed in the community to inform members of the Healthy Start Program and encourage families to complete routine care. Additionally, the Healthy Start Program was highlighted in the CCAH Member Newsletter, which is distributed quarterly to members. Further, CCAH developed a member texting campaign which has been approved by DHCS and is in the implementation phase. This campaign entails a new contract with a vendor to conduct texting campaigns with members, starting with a new member welcome text. CCAH anticipates expanding to campaigns to include texts related to prescription renewal, vaccine reminders, well-check reminders,

2022–23 External Quality Review Recommendations Directed to CCAH	Actions Taken by CCAH to Address the External Quality Review Recommendations
	and flu vaccine reminders. The first campaign is set to launch in fall 2024. Additional member strategies under development in Merced County to help with improving access to preventive services include support for mobile mammography to increase access to breast cancer screenings, a second annual health fair to build trust in the community and provide flu vaccinations in October, and a new point of service member incentive to begin in September to help close gaps for flu vaccinations for members under 2 years of age and well-child visits for members 12 to 17 years of age. Other activities include partnering with stakeholders in Merced County on events, including backpack immunization events, which encourage students to prepare for school and receive the recommended vaccinations. Additionally, CCAH partnered with the Merced County Office of Education and Dignity Health to help launch educational campaigns as well as school site immunization clinics.

Assessment of CCAH's Self-Reported Actions

HSAG reviewed CCAH's self-reported actions in Table C.7 and determined that CCAH adequately addressed the 2022–23 EQR recommendation.

CCAH noted that all measurement year 2022 performance measure rates below the MPLs were in Merced County. CCAH indicated that based on measurement year 2022 performance, the MCP focused quality improvement efforts in Merced County, implementing member- and provider-focused interventions including:

- Provider-Focused Interventions
  - Allocated funding to support providers who had challenges hiring and retaining staff which resulted in these providers being able to expand hours to offer after-hours and weekend appointments.

  - Provided equipment reimbursement for point-of-care blood lead screenings to reduce barriers and increase member access to these screenings.
  - Expanded workforce recruitment and technology grants.
  - Launched a Provider Partnership Pilot Program with the largest provider clinics to focus on improving performance related to pediatric well-child visits.
  - Revised CCAH's primary care incentive payment program to include additional payment to support geographically disadvantaged communities and address disparities.
- Member-Focused Interventions
  - Implemented and promoted a member incentive program for members who complete immunizations, well-child visits, or well-care visits.
  - Developed and began implementing a texting campaign to welcome new members. CCAH indicated plans to expand the campaign to include texts related to prescription renewal, well-check reminders, and vaccine reminders.
  - Partnered with community organizations to promote the importance of completing preventive services and receiving recommended vaccinations.

The interventions CCAH implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023 for Merced County:

- *Breast Cancer Screening—Total*
- *Child and Adolescent Well-Care Visits—Total*

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CCAH

Based on the overall assessment of CCAH's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of CCAH's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned a *High Confidence* level to CCAH's 2023 nonclinical PIP submission, reflecting that the MCP built a robust foundation in the Design stage of its nonclinical PIP.
- The HSAG auditor determined that CCAH followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.

- Across both reporting units for measure rates that HSAG compared to benchmarks in measurement year 2023, CCAH performed above the HPLs for 14 rates.
- Based on its performance measure results, CCAH performed better in Monterey/Santa Cruz counties, where it met or exceeded the MPLs for 16 performance measure rates compared to 10 rates for Merced County.
- DHCS' 2024 compliance review scores for CCAH show that the MCP was fully compliant with all CFR standards.
- During the NAV audit process, HSAG noted that CCAH conducted quarterly provider directory validation activities to ensure that the MCP maintained accurate and complete provider information.

Opportunities for Improvement

- HSAG's 2024 PIP validation determined that CCAH failed to include all required details of its PIP processes for both clinical and nonclinical PIPs.
- CCAH performed below the MPLs in measurement year 2023 for the following 10 of 36 measure rates that HSAG compared to benchmarks (28 percent):
  - *Childhood Immunization Status—Combination 10* for Merced County
  - *Chlamydia Screening in Women—Total* for Merced County
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* for Merced County and Monterey/Santa Cruz counties
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* for Merced County and Monterey/Santa Cruz counties
  - *Immunizations for Adolescents—Combination 2* for Merced County
  - *Lead Screening in Children* for Merced County
  - Both *Well-Child Visits in the First 30 Months of Life* measures for Merced County
- During the NAV audit process, CCAH reported challenges with internal monitoring of provider ratios due to uncertainty in guidelines of expected methodologies to be used. In addition, as part of its internal monitoring, CCAH used a different methodology for calculation of member addresses than the methodology referenced in APLs distributed by DHCS for network adequacy calculation.

2023–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure CCAH includes all required information in the MCP's 2025 annual clinical and nonclinical PIP submissions.
- Based on the audited performance measure rates changing from reporting unit level in measurement year 2023 to plan level in measurement year 2024, and the counties in which the MCP operates changing as of January 1, 2024, CCAH should assess measurement year 2023 performance to determine priority areas for improvement. The MCP should continue implementing interventions that have resulted in positive outcomes and identify new quality improvement strategies as applicable to address factors affecting performance.

- Work with DHCS to identify and clarify methodologies used by DHCS for calculation of network adequacy indicators, to ensure CCAH's efforts are meeting DHCS' expectations.

CCAH's response to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of CCAH as well as the plan's progress with addressing these recommendations.

Community Health Group Partnership Plan

Follow-Up on Prior Year Recommendations

Table C.8 provides the 2022–23 EQR recommendations directed to CHG, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.8 to preserve the accuracy of CHG's self-reported actions.

Table C.8—CHG's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to CHG	Actions Taken by CHG to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure CHG meets all CFR standard requirements moving forward.	To address the findings from DHCS' compliance review, CHG has worked diligently with DHCS to implement corrective actions outlined in the CAP issued on February 17, 2023. On April 24, 2024, DHCS confirmed that CHG had successfully addressed all issues, resulting in the closure of the CAP. Moving forward, CHG will continue to adhere to CFR standard requirements to ensure ongoing compliance. Please note that DHCS only identified findings in the Medical Audit portion of the compliance review. DHCS identified no findings in the ANC, quality improvement process, or EDV components as part of DHCS' compliance review scoring process.
2. Assess the factors that contributed to CHG performing below the MPL in measurement year 2022 for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure and implement quality improvement strategies that target the identified factors.	Factors that contributed to CHG performing below the MPL for *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure include 1) untimely notifications of members accessing the emergency department, 2) emergency department notifications without a diagnosis, 3) member disengagement or refusal to attend visits, and 4) incomplete all-payor data files. Quality improvement strategies that CHG implemented to target the identified factors included:

2022–23 External Quality Review Recommendations Directed to CHG	Actions Taken by CHG to Address the External Quality Review Recommendations
	♦ Worked to improve the timeliness and completeness of ADT files from the San Diego Health Exchange. ♦ Worked to obtain files directly from San Diego County. ♦ Conducted field visits to locate and connect the member with a telehealth provider. ♦ Conducted telephonic outreach to members upon notification of an emergency department discharge to set up in-person or telehealth follow-up visits. ♦ Collaborated and continue to collaborate with San Diego County and other San Diego County MCPs to address the identified factors at a countywide level.

Assessment of CHG's Self-Reported Actions

HSAG reviewed CHG's self-reported actions in Table C.8 and determined that CHG adequately addressed the 2022–23 EQR recommendations. CHG indicated that all findings from DHCS' most recent compliance review scoring process were from DHCS' Medical Audit of the MCP. CHG indicated that the MCP worked with DHCS to implement corrective actions to address the findings and that on April 24, 2024, DHCS closed the MCP's CAP.

To address CHG performing below the MPL for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure in measurement year 2022, the MCP reported implementing strategies to improve:

- Timely notification of members accessing the emergency department.
- Data quality.
- Outreach to members following discharge from the emergency department to schedule follow-up visits.

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CHG

Based on the overall assessment of CHG's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for

improvement, and recommendations for the plan. Note that all of CHG's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to CHG's 2023 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in the Design stage of each PIP.
- HSAG assigned a *Moderate Confidence* level to CHG's 2024 clinical PIP submission, reflecting that the MCP built a robust foundation in the Design stage of its clinical PIP.
- The HSAG auditor determined that CHG followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- CHG reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for CHG show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, HSAG noted that CHG:
  - Established rigorous and comprehensive quality assurance checks to ensure accuracy and completeness of source data utilized for network adequacy monitoring and reporting, in addition to its data integration, reconciliation, and internal calculations processes.
  - Met all mandatory provider types required by DHCS, except one, which was not available in the MCP's service area.

Opportunities for Improvement

- HSAG's 2024 PIP validation determined that CHG failed to include all required details of its PIP processes for its nonclinical PIP.
- CHG performed below the MPLs in measurement year 2023 for the following two of 18 measure rates that HSAG compared to benchmarks (11 percent):
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for CHG:
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210

  - Grievance and Appeal Systems—§438.228
  - Enrollee Rights—§438.100
- During the NAV audit process, HSAG noted that CHG conducted manual data entry of provider data from symplr (eVIPS) into QNXT.

2023–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure CHG includes all required information in the MCP's 2025 annual nonclinical PIP submission.
- For measures for which CHG performed below the MPLs in measurement year 2023, identify the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, CHG should determine whether the interventions described in Table C.8 need to be revised or abandoned based on intervention evaluation results.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure CHG meets all CFR standard requirements moving forward:
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Enrollee Rights—§438.100
- Although CHG had many quality assurance checks and validations in place, explore options to automate data transfer from symplr (eVIPS) to QNXT.

CHG's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of CHG as well as the plan's progress with addressing these recommendations.

Community Health Plan Imperial Valley

DHCS' contract with CHPIV became effective January 1, 2024; therefore, the MCP only participated in activities with review or implementation dates on or after January 1, 2024.

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CHPIV

Based on CHPIV's annual PIP submission, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan.

Strengths

HSAG assigned *High Confidence* levels to CHPIV's 2024 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of each PIP.

Opportunities for Improvement

HSAG identified no opportunities for improvement for CHPIV based on HSAG having only PIP validation results for inclusion in this EQR technical report and HSAG assigning *High Confidence* levels to both the clinical and nonclinical PIPs.

2023–24 External Quality Review Recommendations

HSAG has no recommendations for CHPIV based on the EQR.

Contra Costa Health Plan

Follow-Up on Prior Year Recommendations

Table C.9 provides the 2022–23 EQR recommendations directed to CCHP, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.9 to preserve the accuracy of CCHP's self-reported actions.

Table C.9—CCHP's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to CCHP	Actions Taken by CCHP to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure CCHP meets all CFR standard requirements moving forward.	Based on the CFR compliance review scoring, CCHP had no findings in the areas of Health Information Systems/Encounter Data Validation (§438.242), Assurance of Adequate Capacity and Services/ANC (§438.207), and Quality Assessment and Performance Improvement Program (§438.330). As part of the 2022 DHCS Medical Audit portion of the compliance review, CCHP had no findings in the areas of Availability of Services (§438.206), Provider Selection (§438.214), Practice Guidelines (§438.236), Disenrollment: Requirements and Limitations (§438.56), or Emergency and Poststabilization Services (§438.114). As part of the 2022 DHCS Medical Audit, CCHP had findings in the areas of Coordination and Continuity of Care (§438.208), Coverage and Authorization of Services (§438.210), Confidentiality (§438.224), Grievance and Appeal Systems (§438.228), Sub-contractual Relationships and Delegation (§438.230), and Enrollee Rights (§438.100). CCHP has worked to address all findings from the 2022 DHCS Medical Audit, and DHCS closed the MCP's CAP in 2023.

2022–23 External Quality Review Recommendations Directed to CCHP	Actions Taken by CCHP to Address the External Quality Review Recommendations
	A summary of activities follows: **Coordination and Continuity of Care (§438.208)** CCHP took significant steps to improve coordination and continuity of care. Efforts included implementing workflows to ensure all components of the IHA were met. **Coverage and Authorization of Services (§438.210)** To enhance coverage and authorization processes, CCHP ensured the timeliness of prior authorization decisions and implemented corrective workflows related to sending written notices of delay for authorization requests within the required time frame. CCHP updated the Notice of Action (NOA) templates to include specific phone numbers and reasons. The utilization management team conducted retraining sessions with providers to ensure clear explanations were included in NOAs, and quarterly evaluations were performed to ensure providers maintained compliance. These actions streamlined the authorization process and ensured members received timely and transparent information about their coverage. **Grievance and Appeal Systems (§438.228)** CCHP updated its grievance and appeals system, ensuring written notice of resolution was provided to members within the required time frames. Proper oversight was ensured by regularly reviewing grievance and appeals processes with CCHP's governing body, the Joint Conference Committee. **Sub-contractual Relationships and Delegation (§438.230)** CCHP improved oversight to ensure that sub-contracts met obligations regarding NOA and language taglines when utilization management was

2022–23 External Quality Review Recommendations Directed to CCHP	Actions Taken by CCHP to Address the External Quality Review Recommendations
	delegated. Ownership and control disclosure forms were completed for subcontractors. **Confidentiality and Enrollee Rights (§438.224 and §438.100)** CCHP made significant improvements to uphold member confidentiality and rights. The organization ensured that background checks and fingerprint scanning were completed for all employees. **Claims Systems Enhancements** CCHP updated its systems to forward all misdirected emergency service claims within required time frames. Additionally, the claims systems were updated to distribute add-on payments for specified family planning services claims. These actions demonstrate CCHP's commitment to addressing audit findings, enhancing the quality of care, and ensuring compliance with all regulatory requirements.
2. For measures for which CCHP performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors.	In measurement year 2022, CCHP's performance fell below the MPLs for two measures: *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* and *Lead Screening in Children*. To address these issues, CCHP implemented targeted quality improvement strategies that have yielded significant improvements. ***Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*:** CCHP implemented several performance improvement strategies to enhance follow-up care for patients seen in the emergency department for mental health issues:

2022–23 External Quality Review Recommendations Directed to CCHP	Actions Taken by CCHP to Address the External Quality Review Recommendations
	♦ **Partnerships:** Established a working group with county behavioral health and public health Choosing Change program to improve follow-up and screening processes after emergency department visits. This group meets weekly to move forward on improvement projects. ♦ **Follow-up Calls:** Designed a process to conduct follow-up calls after receiving emergency department notifications and coordinated for members an appointment for specialty mental health, referral to a non-specialty mental health provider, or a linkage to a substance abuse program. ♦ **ADT Feeds:** Implemented ADT feeds to enhance the timeliness of follow-up calls after an emergency department visit for mental health. ♦ **Warm Handoff Procedures:** Collaborated with contracted emergency departments to create a warm handoff procedure from the emergency room to the behavioral health access line, ensuring members could secure an appointment before discharge. As a result of these interventions, CCHP's performance for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure exceeded the MPL in measurement year 2023. ***Lead Screening in Children*:** To improve blood lead screening rates, CCHP implemented a series of provider- and member-focused interventions: ♦ **Point-of-Care Testing:** Increased point-of-care testing by providing point-of-care testing machines to providers. ♦ **Golden Ticket Initiative:** Worked with a provider to implement a "golden ticket" system

2022–23 External Quality Review Recommendations Directed to CCHP	Actions Taken by CCHP to Address the External Quality Review Recommendations
	allowing parents to go to the front of the line at labs for lead testing. ♦ **Parental Education:** Conducted follow-up calls to educate parents on the importance of lead screening. ♦ **Educational Materials:** Collaborated with the county public health department to improve and distribute educational materials to providers. These interventions increased lead screening rates and enhanced overall parental and provider awareness of the importance of lead screening for the Medi-Cal population. By identifying the factors affecting performance and implementing these comprehensive strategies, CCHP has made significant strides in addressing the identified gaps and improving care quality for its members.

Assessment of CCHP's Self-Reported Actions

HSAG reviewed CCHP's self-reported actions in Table C.9 and determined that CCHP adequately addressed the 2022–23 EQR recommendations. CCHP described in detail the steps it took to fully address all findings from DHCS' most recent compliance review scoring process, including:

- Implemented workflows to ensure provider completion of all IHA components.
- Updated NOA templates and conducted trainings with providers to ensure provider compliance with NOA requirements.
- Updated CCHP's grievance and appeals system to ensure the MCP provides written notice of resolution within the required time frames.
- Improved delegated entities' oversight processes.
- Improved policies and processes to uphold member confidentiality and rights.
- Enhanced CCHP's claims systems to improve claims processing.

To address CCHP's performance below the MPL in measurement year 2022 for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure, the MCP reported implementing strategies to improve member follow-up and screening processes

after an emergency department visit and collaborating with contracted emergency departments to create a warm handoff procedure from the emergency room to the behavioral health access line. CCHP indicated that as a result of the implemented strategies, the rate for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure exceeded the MPL in measurement year 2023.

To improve CCHP's performance for the *Lead Screening in Children* measure, the MCP reported implementing provider- and member-focused interventions, including providing point-of-care testing machines to provider sites and conducting member education. While CCHP reported some improvement in blood lead screening rates, the rate for the *Lead Screening in Children* measure remained below the MPL in measurement year 2023.

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CCHP

Based on the overall assessment of CCHP's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of CCHP's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to CCHP's 2023 and 2024 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of each PIP.
- The HSAG auditor determined that CCHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- CCHP performed above the HPLs for the following measures in measurement year 2023:
  - *Asthma Medication Ratio—Total*
  - *Breast Cancer Screening—Total*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status—Combination 10*
  - *Chlamydia Screening in Women—Total*
  - *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - *Immunizations for Adolescents—Combination 2*
  - Both *Prenatal and Postpartum Care* measures

  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- CCHP reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for CCHP show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, CCHP demonstrated its capability of maintaining an adequate provider network to service its members which included comprehensive contracting, provider data maintenance, and reporting methods. Additionally, HSAG identified no specific opportunities for improvement related to CCHP's data collection and management processes used to inform network adequacy standard and indicator calculations.

Opportunities for Improvement

- CCHP performed below the MPLs in measurement year 2023 for the following three of 18 measure rates that HSAG compared to benchmarks (17 percent):
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
  - *Lead Screening in Children*
  - *Topical Fluoride for Children—Dental or Oral Health Services—Total*
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for CCHP:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Health Information Systems—§438.242

2023–24 External Quality Review Recommendations

- For measures for which CCHP performed below the MPLs in measurement year 2023, identify the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, CCHP should determine whether the member- and provider-focused interventions described in Table C.9 need to be revised or abandoned based on intervention evaluation results.

- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure CCHP meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Health Information Systems—§438.242

CCHP's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of CCHP as well as the plan's progress with addressing these recommendations.

Gold Coast Health Plan

Follow-Up on Prior Year Recommendations

Table C.10 provides the 2022–23 EQR recommendations directed to GCHP, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.10 to preserve the accuracy of GCHP's self-reported actions.

Table C.10—GCHP's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to GCHP	Actions Taken by GCHP to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure GCHP meets all CFR standard requirements moving forward.	GCHP worked with the DHCS Audit Monitoring Unit through a CAP to resolve findings from the 2023 Medical Audit. GCHP submitted to DHCS monthly updates to the CAP beginning on January 3, 2024, with the remediation required under the CAP being completed on June 4, 2024. DHCS closed the CAP on June 7, 2024. DHCS did not communicate with GCHP about any other specific CFR compliance review findings other than those from the DHCS Medical Audit.
2. For measures for which GCHP performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, GCHP should determine whether the MCP's member- and provider-focused interventions to improve well-child visit, well-care visit, and chlamydia screening rates need to be revised or	**Well-Child and Well-Care Visits** In measurement year 2022, GCHP performed below the MPLs for the *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measures. To improve the rates for these measures, GCHP completed a SWOT analysis which the MCP used as the framework to implement the following interventions: ♦ GCHP collaborated with low-performing clinics to identify barriers to increasing well-care visits, share best practices, and evaluate the effectiveness of process improvements.

2022–23 External Quality Review Recommendations Directed to GCHP	Actions Taken by GCHP to Address the External Quality Review Recommendations
abandoned based on intervention evaluation results.	♦ GCHP's Quality Improvement Department provided ongoing support to network providers on quality initiatives through the monthly Joint Quality Operation meetings with each clinic system and the quarterly network-wide quality improvement collaborations. ♦ GCHP led initiatives such as the expansion of the well-child exam point-of-care member incentive program; a telephonic outreach program to assist members with scheduling well-child exams; and the launching of the Quality Incentive Pool & Program, enabling clinic systems to implement process improvements within their organizations that helped improve their measurement year 2023 rates for the *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measures. ♦ GCHP's Quality Improvement Department hosted a virtual Well-Child Visit Training Lunch and Learn on May 10, 2023, that was attended by 200 individuals, including providers, clinic staff members, and operations managers. The training provided an opportunity to expand knowledge on well-care visits, review best practice guidelines, review the *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure technical specifications, and address any questions or concerns. A primary concern addressed was clarification on Medi-Cal's well-child exam reimbursement guidelines. GCHP confirmed we provide reimbursement for all well-child visits regardless of the amount of time that has elapsed between these preventive visits. To support this, GCHP sent a provider bulletin

2022–23 External Quality Review Recommendations Directed to GCHP	Actions Taken by GCHP to Address the External Quality Review Recommendations
	article that outlined reimbursement information for well-child visits. A post-training survey was sent to all attendees, and GCHP received 35 responses. Many of the respondents reported that they planned to change their well-child exam scheduling practices based on the Medi-Cal reimbursement guidelines. ♦ GCHP expanded the well-care visit point-of-care member incentive program to 19 clinics in 2023, which strengthened clinic partnerships and provided opportunities to address barriers and focus member outreach. ♦ On November 13, 2023, GCHP's chief medical officer partnered with Amigo Baby's medical program director to host a Facebook Live event that promoted the importance of routine health screenings. ♦ In December 2023, GCHP launched a social media campaign on Instagram to promote the importance of well-child exams in children 0 to 21 years of age. ♦ GCHP's Quality Improvement Department collaborated with the Women, Infants, and Children (WIC) Program to launch a texting campaign on the importance of well-child exams. Scripts were developed, but due to the WIC Program's limited resources, the texting message campaign launched in 2024. ♦ GCHP sponsored two Healthy Return to School events that were hosted by the Westminster Free Clinic on August 9 and 15, 2023. GCHP provided 200 backpacks that were filled with school supplies and oral health kits. GCHP staff members attended the two events to help distribute backpacks to children, promote the importance of well-child exams, provide health education resources, and provide information on GCHP benefits.

2022–23 External Quality Review Recommendations Directed to GCHP	Actions Taken by GCHP to Address the External Quality Review Recommendations
	In measurement year 2023, GCHP's performance significantly improved for both the *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measures, surpassing the MPLs. The rate for the *Child and Adolescent Well-Care Visits—Total* measure improved by 7.46 percentage points. The rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure improved by 4.8 percentage points, meeting the 75th percentile benchmark; and remarkably, the rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure improved by 13.32 percentage points. Based on this marked performance improvement, GCHP will adopt and continue all interventions implemented in measurement year 2023 to sustain improved performance measure rates. **Chlamydia Screening** In measurement year 2022, GCHP's performance was below the MPL for the *Chlamydia Screening in Women—Total* measure. To improve performance, GCHP completed a SWOT analysis which was used as the framework to implement the following interventions to increase chlamydia screenings. ♦ GCHP's Quality Improvement Department collaborated with low-performing clinics to close care gaps for adolescent members who were due for both a chlamydia screening and well-child visit. To increase member engagement, members were informed they would receive a $25 gift card at the clinic after completing their well-child exam. Of the 32 members contacted, 17 completed their

2022–23 External Quality Review Recommendations Directed to GCHP	Actions Taken by GCHP to Address the External Quality Review Recommendations
	exam along with their chlamydia test and received a gift card. ♦ GCHP's Quality Improvement Department hosted a virtual Chlamydia Screening Provider Education Lunch and Learn on June 7, 2023. The lunch and learn was attended by 58 clinic staff members. The training reviewed best practice guidelines, reviewed the *Chlamydia Screening in Women—Total* measure specifications, and addressed attendees' questions and concerns. ♦ GCHP's Quality Improvement Department provided ongoing support to network providers on quality initiatives through the monthly Joint Quality Operation meetings with each clinic system and the quarterly network-wide quality improvement collaborations. ♦ GCHP launched the Quality Incentive Pool & Program, enabling clinic systems to implement process improvements within their organizations that helped improve their measurement year 2023 rates for the *Chlamydia Screening in Women—Total* measure. ♦ Ongoing data validation activities with one clinic system revealed that NCQA had removed 20 chlamydia screening Logical Observation Identifiers Names and Codes (LOINC) codes from NCQA's measurement year 2023 Value Set Directory (VSD) that was published by NCQA in March 2023. This caused *Chlamydia Screening in Women—Total* measure rates to decline because these LOINC codes are commonly used by lab vendors. GCHP submitted an NCQA Policy Clarification Support request to advocate for the LOINC codes to be reinstated in the VSD, and on November 30, 2023, NCQA re-released an updated VSD with the LOINC codes reinstated, resulting in an improved

2022–23 External Quality Review Recommendations Directed to GCHP	Actions Taken by GCHP to Address the External Quality Review Recommendations
	rate for the *Chlamydia Screening in Women—Total* measure. ♦ GCHP partnered with Planned Parenthood to present Planned Parenthood's Teen Talk curriculum to the Ventura County Office of Education's Health Services Standards and Practices virtual monthly meeting to promote sexually transmitted infection (STI) screening among sexually active students. ♦ In April 2023, GCHP launched a social media campaign on Instagram to promote STI Awareness Month by posting two resources from the Centers for Disease Control and Prevention: "Yes Means Test" and "Get Your Self Tested" programs. In measurement year 2023, GCHP significantly improved performance for the *Chlamydia Screening in Women—Total* measure, with an improvement of 10.33 percentage points, not only surpassing the MPL but reaching the 75th percentile benchmark. Based on this marked performance improvement, GCHP will adopt and continue all interventions implemented in measurement year 2023 to sustain improved *Chlamydia Screening in Women—Total* measure rates.

Assessment of GCHP's Self-Reported Actions

HSAG reviewed GCHP's self-reported actions in Table C.10 and determined that GCHP adequately addressed the 2022–23 EQR recommendations. GCHP indicated that all findings from DHCS' most recent compliance review scoring process were from DHCS' Medical Audit of the MCP. GCHP indicated that the MCP submitted monthly updates to DHCS regarding corrective action the MCP was implementing to address the findings, and on June 7, 2024, DHCS closed GCHP's CAP.

GCHP reported using SWOT analyses as the framework for implementing member- and provider-focused interventions to improve performance on measures for which the MCP

performed below the MPLs in measurement year 2022. GCHP provided detailed descriptions of the interventions, which included:

- Collaborated with providers and community organizations to identify barriers to care, share best practices, evaluate improvement efforts, improve access to needed services, and conduct member outreach and education.
- Conducted provider and member education.
- Expanded the MCP's provider incentive program.
- Offered member incentives for completing well-child exams.

The interventions GCHP implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023:

- *Child and Adolescent Well-Care Visits—Total*
- *Chlamydia Screening in Women—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for GCHP

Based on the overall assessment of GCHP's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of GCHP's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to GCHP's 2023 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in the Design stage of each PIP.
- HSAG assigned a *High Confidence* level to GHCP's 2024 nonclinical PIP submission, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of its nonclinical PIP.
- The HSAG auditor determined that GCHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.

- GCHP performed above the HPLs for the following measures in measurement year 2023:
  - *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - Both *Prenatal and Postpartum Care* measures
- GCHP reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for GCHP show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, GCHP demonstrated the capability of maintaining an adequate provider network to service its members which included comprehensive contracting, provider data maintenance, and monitoring and reporting methods. GCHP addressed gaps in its network by submitting AAS requests to DHCS and increasing contracting efforts to fill network gaps. Additionally, HSAG identified no specific opportunities for improvement related to GCHP's data collection and management processes used to inform network adequacy standard and indicator calculations.

Opportunities for Improvement

- HSAG's 2024 PIP validation determined that GCHP failed to include all required details of its PIP processes for its clinical PIP.
- GCHP performed below the MPLs in measurement year 2023 for the following three of 18 measure rates that HSAG compared to benchmarks (17 percent):
  - *Asthma Medication Ratio—Total*
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for GCHP:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208

2023–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure GCHP includes all required information in the MCP's 2025 annual clinical PIP submission.
- For measures for which GCHP performed below the MPLs in measurement year 2023, identify the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors.

- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure GCHP meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208

GCHP's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of GCHP as well as the plan's progress with addressing these recommendations.

Health Net Community Solutions, Inc.

Follow-Up on Prior Year Recommendations

Table C.11 provides the 2022–23 EQR recommendations directed to Health Net, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.11 to preserve the accuracy of Health Net's self-reported actions.

Table C.11—Health Net's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to Health Net	Actions Taken by Health Net to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Health Net meets all CFR standard requirements moving forward.	Related to availability of services, Health Net has taken multiple steps to address providers who did not comply with in-office wait times, provider call answer wait times, and appointment wait time standards. Activities included sending provider communications, conducting an in-office wait time survey in measurement year 2024, identifying providers not responding to members' phone calls via grievance data, and requesting a resolution from identified providers. Additional actions included implementing a process to engage participating physician groups (PPGs) to provide an attestation of notification to PCPs who do not meet appointment wait time standards, including completing interventions within 60 days. Related to continuity of care, Health Net updated its member notification letters for approved continuity of care requests, which include all required elements. Regarding subcontractual relationships and delegation, Health Net is still working with DHCS to negotiate a process in which the MCP can address the findings moving forward.

2022–23 External Quality Review Recommendations Directed to Health Net	Actions Taken by Health Net to Address the External Quality Review Recommendations
2. For measures for which Health Net performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Health Net should determine whether the MCP's member- and provider-focused interventions need to be revised or abandoned based on intervention evaluation results. a. Based on measurement year 2022 performance measure results, Health Net should prioritize implementing quality improvement strategies in Kern, San Joaquin, and Stanislaus counties.	For the measures with rates below the MPLs in measurement 2022, Health Net implemented initiatives to address access to care and quality of services provided to members as noted in the MCP's Quality Work Plan: ♦ Quality Evaluating Data to Generate Excellence (EDGE) Strategy: A strategy with a hyper-local approach to quality improvement that fosters continuous quality improvement processes at the practice and provider group level. ♦ Concierge Program: A program designed to improve engagement with members who are less likely to utilize their health care services and to minimize barriers to receiving preventive screening services for these members, while facilitating the patient to clinic transition through an enhanced member experience. ♦ Project Extension for Community Healthcare Outcomes (ECHO): A project that targets rural counties in California to address the high rates of diabetes by connecting PCPs with resources to manage patients with diabetes to improve care. At each session, subject matter experts provide guidance using a multidisciplinary team approach to help providers address patients' complex diabetes-related health care needs. In addition to the quality improvement strategies listed above, based on the measurement year 2022 performance, Health Net also deployed the following quality improvement strategies for Kern, San Joaquin, and Stanislaus counties: ♦ Collaborated with local FQHCs to integrate their electronic health records (EHRs) with Cozeva, Health Net's population health management tool. ♦ Deployed strategies to improve engagement between members and their assigned PCPs through the community health worker benefit. ♦ Collaborated with safety net providers to assist in preparing their data for supplemental data

2022–23 External Quality Review Recommendations Directed to Health Net	Actions Taken by Health Net to Address the External Quality Review Recommendations
	exchange with Health Net to ensure all claims data have been captured and credited to providers.

Assessment of Health Net's Self-Reported Actions

HSAG reviewed Health Net's self-reported actions in Table C.11 and determined that Health Net adequately addressed the 2022–23 EQR recommendations. Health Net described the steps it has taken to fully resolve all findings from DHCS' most recent compliance review scoring process, including:

- Implemented provider monitoring processes related to availability of services requirements.
- Updated the MCP's member notification letters for approved continuity of care requests to include all required elements.

Health Net indicated that the MCP is working with DHCS to determine the best process for addressing the compliance review findings related to subcontractual relationships and delegation.

Health Net reported implementing member- and provider-focused interventions to improve performance on measures for which the MCP performed below the MPLs in measurement year 2022, including:

- Supported providers in implementing continuous quality improvement processes.
- Implemented a member engagement program to minimize barriers to receiving preventive screening services.
- Provided PCPs in rural areas with resources to better manage their patients with diabetes.

Health Net reported targeted interventions for Kern, San Joaquin, and Stanislaus counties, including:

- Collaborated with local FQHCs to integrate their EHRs with Health Net's population health management tool, Cozeva.
- Used community health workers to improve engagement between members and their assigned PCPs.
- Collaborated with safety net providers to ensure all claims data were captured and credited to providers accurately.

The interventions Health Net implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023:

- *Cervical Cancer Screening* for Los Angeles County
- *Controlling High Blood Pressure—Total* for Stanislaus County

- *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for Stanislaus County
- *Lead Screening in Children* for Tulare County

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Health Net

Based on the overall assessment of Health Net's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Health Net's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to Health Net's 2023 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in the Design stage of each PIP.
- HSAG assigned a *High Confidence* level to Health Net's 2024 nonclinical PIP submission, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of its nonclinical PIP.
- The HSAG auditor determined that Health Net followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- Health Net performed above the HPLs for the following measures in measurement year 2023:
  - *Chlamydia Screening in Women—Total* for Los Angeles County, Sacramento County, and Tulare County
  - *Controlling High Blood Pressure—Total* in Tulare County
  - Both *Prenatal and Postpartum Care* measures for Tulare County
- Based on its performance measure results across all reporting units, Health Net performed better in Tulare and Los Angeles counties, where the MCP met or exceeded the MPLs for 11 and 10 performance measure rates, respectively.
- DHCS' 2024 compliance review scores for Health Net show that the MCP was fully compliant with most CFR standards.

- During the NAV audit process, Health Net demonstrated the capability of:
  - Maintaining an adequate provider network to service its members which included comprehensive contracting, provider data maintenance, and monitoring and reporting methods. Health Net addressed gaps in its network by submitting AAS requests to DHCS and increasing contracting efforts to fill network gaps.
  - Ensuring the accuracy of its provider network by conducting rigorous quality assurance measures which included outbound outreach to providers to attest data, providing multiple reminders, and conducting rigorous quality assurance programs which included regular audits of randomly selected provider data updates.

Opportunities for Improvement

- HSAG's 2024 PIP validation determined that Health Net failed to include all required details of its PIP processes for its clinical PIP.
- Across all reporting units in measurement year 2023, Health Net performed below the MPLs for 88 of the 126 measure rates that HSAG compared to benchmarks (70 percent).
- Health Net has remaining findings to resolve from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for Health Net:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Grievance and Appeal Systems—§438.228
- During the NAV audit process, although Health Net demonstrated that it was conducting monitoring and oversight, the MCP indicated challenges in aligning methodologies for calculation of network time/distance indicators to DHCS-published methodologies.

2023–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure Health Net includes all required information in the MCP's 2025 annual clinical PIP submission.
- Based on the audited performance measure rates changing from reporting unit level in measurement year 2023 to plan level in measurement year 2024, and the counties in which the MCP operates changing as of January 1, 2024, Health Net should assess measurement year 2023 performance to determine priority areas for improvement. The MCP should continue implementing interventions that have resulted in positive outcomes and identify new quality improvement strategies as applicable to address factors affecting performance.
- Work with DHCS to fully resolve the findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.

- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure Health Net meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Grievance and Appeal Systems—§438.228
- Evaluate the DHCS ANC APL and outreach to DHCS to ensure Health Net is in alignment with DHCS' expectations for calculating time/distance standards.

Health Net's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of Health Net as well as the plan's progress with addressing these recommendations.

Health Plan of San Joaquin

Follow-Up on Prior Year Recommendations

Table C.12 provides the 2022–23 EQR recommendations directed to HPSJ, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.12 to preserve the accuracy of HPSJ's self-reported actions.

Table C.12—HPSJ's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to HPSJ	Actions Taken by HPSJ to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure HPSJ meets all CFR standard requirements moving forward.	**Category 1—Utilization Management** (Coverage and Authorization of Services) Finding 1.2.1: HPSJ did not use the appropriate coverage criteria to deny medical service requests. Actions Taken to Remediate Finding: HPSJ's compliance team worked with internal business owners to identify the root cause of the finding and discovered that there was a lack of a formal process to ensure that utilization management reviewers use the appropriate criteria to make medical coverage decisions. The utilization management team was tasked with the following items that needed to be implemented in order to close the CAP: ♦ Revise policies and procedures. ♦ Provide training for utilization staff members, medical directors, and physician reviewers. ♦ Revise the interrater reliability desk-level procedure. ♦ Update audit tools to include reviews of cases subject to future updated medical necessity criteria. CAP Close-Out: HPSJ provided DHCS with monthly status updates. DHCS closed this finding on November 6, 2023.

2022–23 External Quality Review Recommendations Directed to HPSJ	Actions Taken by HPSJ to Address the External Quality Review Recommendations
	Category 2—Case Management and Coordination of Care (Availability of Services) DHCS Findings: Finding 2.1.1: HPSJ did not ensure the provision of oral or written blood lead anticipatory guidance to the parent(s) or guardian(s) of a child member at each periodic health assessment starting at 6 months of age and continuing until 72 months of age. Finding 2.1.2: HPSJ did not ensure the provision of a blood lead screenings test to members at 12 months to 72 months of age. Actions Taken to Remediate Findings: HPSJ's compliance team worked with internal business owners and identified that the root cause for these two findings was due to the audit tool's narrow scope, which was unable to identify trends at the provider level regarding compliance with the anticipatory guidance. To address these issues, HPSJ expanded its oversight and reporting mechanisms for blood lead screening anticipatory guidance by: ♦ Updating the policy and procedure to include appropriate language. ♦ Updating the audit tool to ensure compliance with required documentation. ♦ Disseminating a provider alert for reeducation on required blood lead screenings. ♦ Providing a guidance document to all PCPs regarding appropriate documentation in medical records of anticipatory guidance, the blood test, and/or parent/caregiver refusals. CAP Close-Out: HPSJ provided DHCS with monthly status updates. DHCS closed this finding on September 22, 2023.

2022–23 External Quality Review Recommendations Directed to HPSJ	Actions Taken by HPSJ to Address the External Quality Review Recommendations
	Category 3—Access and Availability of Care (Enrollee Rights) DHCS Findings: Finding 3.1.1: HPSJ did not ensure that corrective actions were implemented for providers who did not comply with appointment wait time standards. Finding 3.1.2: HPSJ did not monitor the wait times for providers to answer and return calls to members. Finding 3.1.3: HPSJ did not have a policy and procedure to monitor providers' compliance with wait times in the providers' offices for scheduled appointments. Finding 3.2.1: HPSJ did not ensure the use of a DHCS-approved physician certification statement form, complete with required information, to determine the appropriate level of service for Medi-Cal members. Finding 3.2.2: HPSJ did not ensure that its non-emergency medical transportation providers are enrolled in the Medi-Cal program. Actions Taken to Remediate Findings: HPSJ worked with internal business partners and identified that the root cause was due to staff members' lack of understanding of regulatory requirements. Business owners updated policies and procedures and desk-level procedures, as well as began monitoring noncompliance using surveys and grievances escalating to the Quality Operations Committee. HPSJ also issued CAPs to noncompliant providers and provided training to applicable staff members. CAP Close-Out: HPSJ provided DHCS with monthly status updates. DHCS closed this finding on November 6, 2023.

2022–23 External Quality Review Recommendations Directed to HPSJ	Actions Taken by HPSJ to Address the External Quality Review Recommendations
	Category 4—Member's Rights (Grievance and Appeal Systems) Finding 4.1.1: HPSJ did not ensure full grievance resolution prior to sending resolution letters. Actions Taken to Remediate Findings: A detailed root cause analysis was documented, detailing staff members' lack of consistent understanding of regulatory requirements. HPSJ's CAP included: ♦ Updating policies and procedures. ♦ Updating the grievance process document to ensure that members are notified in writing of the status and estimated date of resolution. ♦ Providing staff trainings. ♦ Developing a workflow process in collaboration with the grievance and provider services departments. CAP Close-Out: HPSJ provided DHCS with monthly status updates. DHCS closed this finding on December 29, 2023.
2. For measures for which HPSJ performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors.	HPSJ performance in measurement year 2022: ♦ Performance within the Behavioral Health domain was mixed when compared to measurement year 2021. HPSJ is greatly affected by ineffective methods of identifying members who present at the emergency department for issues related to substance use and mental illness. Emergency department claims reports collected by HPSJ were not always actionable in a timely manner because of claims lag. ♦ Performance within the Chronic Disease Management domain improved in almost every reporting unit when compared to measurement year 2021. Despite this improvement, HPSJ experienced barriers related to data capture for blood pressure readings and lab results. Blood pressure readings are not readily coded by

2022–23 External Quality Review Recommendations Directed to HPSJ	Actions Taken by HPSJ to Address the External Quality Review Recommendations
	rendering providers, and lab results are not always returned in the data along with the procedure codes. ♦ Performance within the Children's Health domain shows declining vaccination rates for members 2 years of age and overall improvement for almost all age groups compared to measurement year 2021. HPSJ has experienced challenges related to members' engagement and willingness to complete vaccine services. Caregivers have a high no-show rate and vaccine hesitancy, and vaccine negotiation is becoming more prevalent among members and caregivers. ♦ Performance within the Cancer Prevention domain improved in almost every reporting metric. HPSJ identified opportunities to improve access to mammography services and engagement with cervical cancer screenings. Mobile mammography and additional clinic times are offered more frequently and at more locations. ♦ Performance within the Reproductive Health domain remains strong across reporting years. Opportunities to improve chlamydia screenings exist in one service area. HPSJ strategies to improve quality performance metrics include expanding initiatives that have proven effective and build on lessons learned: ♦ Using MCP and FQHC staff members to align outreach modalities between newsletters, mailers, and calls to increase outreach to members. ♦ Securing a new HEDIS vendor with industry expertise. ♦ Enlisting providers to participate in the HIE and ultimately achieve Data Aggregator Validation certification for greater data capture.

2022–23 External Quality Review Recommendations Directed to HPSJ	Actions Taken by HPSJ to Address the External Quality Review Recommendations
	♦ Offering provider locum grants, lead analyzer grants, and additional MCAS quality measure incentives to improve access to care. ♦ Maintaining member backpack drives and increasing mobile mammography offerings to further incentivize members to seek care.

Assessment of HPSJ's Self-Reported Actions

HSAG reviewed HSPJ's self-reported actions in Table C.12 and determined that HPSJ adequately addressed the 2022–23 EQR recommendations. HPSJ described in detail the steps it took to fully resolve all findings from DHCS' most recent compliance review scoring process, including:

- Conducted root cause analyses.
- Revised policies and procedures based on root cause analyses results.
- Conducted MCP staff member trainings on regulatory requirements.
- Expanded HPSJ's oversight and reporting mechanisms for blood lead screening anticipatory guidance.

HPSJ indicated that based on the MCP's actions, DHCS closed all findings from the compliance review.

HPSJ described the MCP's assessment of its performance across all performance measure domains and reported implementing the following interventions to improve performance on measures for which the MCP performed below the MPLs in measurement year 2022:

- Aligned HPSJ's outreach modalities with FQHCs to expand member outreach.
- Secured a new HEDIS vendor with industry expertise.
- Encouraged providers to participate in the HIE for greater data capture.
- Offered provider grants and incentives to improve access to care.
- Maintained member backpack drives and increased the availability of mobile mammograms.

The interventions HPSJ implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023:

- *Breast Cancer Screening—Total* for Stanislaus County
- *Cervical Cancer Screening* for San Joaquin County
- *Child and Adolescent Well-Care Visits—Total* for San Joaquin County

- *Controlling High Blood Pressure—Total* for San Joaquin County
- *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for Stanislaus County

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for HPSJ

Based on the overall assessment of HPSJ's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of HPSJ's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned a *High Confidence* level to HPSJ's 2023 clinical PIP submission, reflecting that the MCP built a robust foundation in the Design stage of its clinical PIP.
- HSAG assigned a *High Confidence* level to HPSJ's 2024 nonclinical PIP submission, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of its nonclinical PIP.
- The HSAG auditor determined that HPSJ followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- For Stanislaus County, HPSJ performed above the HPLs for the following measures in measurement year 2023:
  - *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - *Prenatal and Postpartum Care—Postpartum Care*
- HPSJ reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for HPSJ show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, HPSJ demonstrated the capability of:
  - Maintaining an adequate provider network to service its members which included comprehensive contracting, provider data maintenance, and monitoring and reporting methods. HPSJ addressed gaps in its network by submitting AAS requests to DHCS and increasing contracting efforts to fill network gaps.

- Ensuring the accuracy of network adequacy indicator calculation and monitoring and reporting metrics by conducting several multi-staffed quality assurance methods to verify accuracy of data.

Opportunities for Improvement

- HSAG's 2024 PIP validation determined that HPSJ failed to include all required details of its PIP processes for its clinical PIP.
- Across both reporting units in measurement year 2023, HPSJ performed below the MPLs for 22 of the 36 measure rates that HSAG compared to benchmarks (61 percent).
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for HPSJ:
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Subcontractual Relationships and Delegation—§438.230
- During the NAV audit process, HPSJ indicated difficulties in obtaining timely and accurate data from delegates, requiring significant oversight and management.

2023–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure HPSJ includes all required information in the MCP's 2025 annual clinical PIP submission.
- Based on the audited performance measure rates changing from reporting unit level in measurement year 2023 to plan level in measurement year 2024, and the counties in which the MCP operates changing as of January 1, 2024, HPSJ should assess measurement year 2023 performance to determine priority areas for improvement. The MCP should continue implementing interventions that have resulted in positive outcomes and identify new quality improvement strategies as applicable to address factors affecting performance.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure HPSJ meets all CFR standard requirements moving forward:
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Subcontractual Relationships and Delegation—§438.230
- Continue to work with delegated providers and establish performance-based metrics that HPSJ can leverage to hold delegates accountable to provide more timely and complete data.

HPSJ's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of HPSJ as well as the plan's progress with addressing these recommendations.

Health Plan of San Mateo

Follow-Up on Prior Year Recommendations

Table C.13 provides the 2022–23 EQR recommendations directed to HPSM, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.13 to preserve the accuracy of HPSM's self-reported actions.

Table C.13—HPSM's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to HPSM	Actions Taken by HPSM to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure HPSM meets all CFR standard requirements moving forward.	HPSM is actively working with DHCS through the audit CAP process to resolve the identified findings from DHCS' compliance review and ensure HPSM meets all CFR standard requirements. HPSM has provided DHCS with a series of corrective action items as defined by DHCS to address each finding within the CAP. The MCP continues to submit evidence/additional information to DHCS to demonstrate compliance with all regulatory requirements and work toward CAP closure.
2. Assess the factors that contributed to HPSM performing below the MPL in measurement year 2022 for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure and implement quality improvement strategies that target the identified factors.	Through member feedback, HPSM learned that many members are unaware of the importance of completing all recommended well-child visits and therefore do not make and/or keep their well-child appointments. Also, through feedback from our Provider Services Department, providers indicate they have limited staff resources to conduct meaningful member outreach to schedule and/or follow up on well-child appointments. To improve performance on the measure, HPSM conducted a SWOT analysis and implemented an action plan.

2022–23 External Quality Review Recommendations Directed to HPSM	Actions Taken by HPSM to Address the External Quality Review Recommendations
	The strategies adopted for the 2023 SWOT for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure were: ♦ Created a permanent, continuous child and youth health population workgroup to improve performance on this measure as well as other preventive care measure outcomes. ♦ Leveraged an established rapport with providers and provider-level care gap reports related to *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure compliance. ♦ Leveraged the MCP's relationship and existing agreement with the San Mateo County Family Home Visiting Program. ♦ Explored the feasibility of a member incentive initiative for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure. These strategies with corresponding action items were implemented through 2023, and HPSM will assess outcomes to determine which strategies will be abandoned, adapted, or adopted. Also, in 2023–24, HPSM is conducting the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* clinical PIP targeting Hispanic members. HPSM is implementing the following two strategies for this PIP: ♦ Leveraging the MCP's relationship and existing agreement with the San Mateo County Family Home Visiting Program to conduct member education. ♦ Implementing a care gap closure provider incentive program for PCPs to encourage PCPs to have more dedicated staff members conduct member outreach.

Assessment of HPSM's Self-Reported Actions

HSAG reviewed HPSM's self-reported actions in Table C.13 and determined that HPSM adequately addressed the 2022–23 EQR recommendations. HPSM indicated that the MCP has submitted information to DHCS to demonstrate compliance with all regulatory requirements and is actively working with DHCS to fully resolve all findings from DHCS' most recent compliance review scoring process.

To address HPSM performing below the MPL for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure in measurement year 2022, the MCP reported that it conducted a SWOT analysis and implemented an action plan. Action plan strategies included:

- Created a child and youth health population workgroup to improve performance on this measure as well as other preventive care measures.
- Used provider gaps-in-care reports to improve measure compliance.
- Leveraged HPSM's relationship with a home visiting program.
- Explored the feasibility of a member incentive initiative.

HPSM also indicated that the MCP is conducting a *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* PIP targeting Hispanic members and is conducting member education and offering provider incentives for PCPs as part of this PIP.

The action plan strategies and PIP interventions may have contributed to the rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure moving from below the MPL in measurement year 2022 to above the MPL in measurement year 2023.

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for HPSM

Based on the overall assessment of HPSM's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of HPSM's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to HPSM's 2023 and 2024 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of each PIP.
- The HSAG auditor determined that HPSM followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- HPSM met or exceeded the MPLs for all 18 performance measure rates that HSAG compared to benchmarks.
- HPSM performed above the HPLs for the following measures in measurement year 2023:
  - *Breast Cancer Screening—Total*
  - *Childhood Immunization Status—Combination 10*
  - *Chlamydia Screening in Women—Total*
  - *Immunizations for Adolescents—Combination 2*
  - Both *Prenatal and Postpartum Care* measures
- DHCS' 2024 compliance review scores for HPSM show that the MCP was fully compliant with seven of the 14 CFR standards.
- During the NAV audit process, HSAG identified no specific opportunities for improvement related to the data collection and management processes HPSM had in place to inform network adequacy standard and indicator calculations and noted that HPSM:
  - Established strong data collection procedures and processes which included data quality control measures to validate member and provider data, promoting reliable and consistent member and provider data management.
  - Enhanced its data management by centralizing member and provider data within one database management system. By housing data in one system, the health plan achieved more efficient reporting and easier data accessibility.

Opportunities for Improvement

- HPSM has remaining findings to resolve from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for HPSM:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Quality Assessment and Performance Improvement Program—§438.330

- Enrollee Rights—§438.100

2023–24 External Quality Review Recommendations

- Work with DHCS to fully resolve the findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure HPSM meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Quality Assessment and Performance Improvement Program—§438.330
  - Enrollee Rights—§438.100

HPSM's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of HPSM as well as the plan's progress with addressing these recommendations.

Inland Empire Health Plan

Follow-Up on Prior Year Recommendations

Table C.14 provides the 2022–23 EQR recommendations directed to IEHP, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.14 to preserve the accuracy of IEHP's self-reported actions.

Table C.14—IEHP's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to IEHP	Actions Taken by IEHP to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure IEHP meets all CFR standard requirements moving forward.	DHCS only identified findings in the DHCS Medical Audit portion of the compliance review. IEHP has resolved the findings identified in DHCS' compliance review scoring process via our closed 2022–23 annual Medical Audit CAP.
2. For measures for which IEHP performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, IEHP should determine whether the MCP's member- and provider-focused interventions to improve cervical cancer screening, child and adolescent immunization, and well-child visit rates need to be revised or abandoned based on intervention evaluation results.	The following are quality improvement activities conducted between July 1, 2023, and June 30, 2024, to address IEHP's measurement year 2022 performance below the MPLs related to cervical cancer screenings, child and adolescent immunizations, and well-child visits. **Root Cause Analyses** IEHP conducted root cause analyses on the following measures with rates that fell below the MPLs: ♦ *Cervical Cancer Screening* ♦ *Child and Adolescent Well-Care Visits—Total* ♦ *Childhood Immunization Status—Combination 10* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Lead Screening in Children* ♦ *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*

2022–23 External Quality Review Recommendations Directed to IEHP	Actions Taken by IEHP to Address the External Quality Review Recommendations
	Quality Improvement Strategies Through the root cause analyses, IEHP identified key insights, barriers, and opportunities for improvement for each measure. Below is a summary of actions taken by IEHP to improve performance on each measure using the insights from the root cause analyses to shape the approaches. Key strategies included: ♦ Increased member incentives. ♦ Expanded member engagement/outreach activities to include help with appointment scheduling. ♦ Increased provider incentives. ♦ Expanded provider education/training and support activities. ♦ Enhanced data capture processes. **Member Incentives** One quality improvement activity that supports IEHP's quality performance is the Member Incentive Program. The goal of the program is to improve quality measure performance by increasing members' engagement in their health care for key preventive care services, including health screenings that support optimal wellness and early treatment interventions. This program provides gift card incentives to eligible members who complete preventive wellness screenings, exams, or immunizations within specific timelines. IEHP's member incentive programs focus on the following: ♦ Completion of flu and rotavirus vaccine series for members ages 0 to 12 months (*Childhood Immunization Status—Combination 10* measure) ♦ Completion of flu vaccine for members ages 13 to 24 months (*Childhood Immunization Status—Combination 10* measure)

2022–23 External Quality Review Recommendations Directed to IEHP	Actions Taken by IEHP to Address the External Quality Review Recommendations
	♦ Completion of human papillomavirus (HPV) vaccine series by age 13 (*Immunizations for Adolescents—Combination 2* measure) ♦ Completion of a blood lead screening by 24 months of age ♦ Both *Well-Child Visits in the First 30 Months of Life* measures ♦ *Child and Adolescent Well-Care Visits* measure for members 16 to 21 years of age ♦ *Cervical Cancer Screening* measure **Member Engagement/Outreach Activities** IEHP devoted a quality engagement specialist to support improvement on the *Child and Adolescent Well-Care Visits—Total* measure. The project consisted of a dedicated IEHP team member embedded in provider offices who outreached to members and scheduled well-visit appointments, provided education on preventive screenings, and reiterated the importance of a yearly visit. To support outreach sustainment, the IEHP team member also trained key provider office staff members on best practices for outreach and scheduling. Additionally, IEHP conducted telephonic outreach campaigns to educate members and caregivers on needed preventive health visits and helped with appointment scheduling as requested. **Increased Provider Incentives** IEHP's IPA and PCP Global Quality P4P programs reward IPAs and providers for high performance and year-over-year improvement in key quality performance metrics. IEHP continued funding this program in 2023, including an additional increase in funding for additional bonus services that introduced additional ways to earn incentive dollars by excelling in key focus areas and through new bonus bundle payments. IEHP also conducts

2022–23 External Quality Review Recommendations Directed to IEHP	Actions Taken by IEHP to Address the External Quality Review Recommendations
	provider P4P meetings throughout the year to support efforts to maximize performance measure improvements. **Provider Education/Training and Support Activities** IEHP quality specialist representatives visited provider offices that demonstrated an opportunity for improvement in the Children's Health domain. During these visits, the quality specialist representative provided information, resources, and best practices/mitigation strategies. Visits included an overview of the following: ♦ Current performance and areas in need of improvement, including potential countermeasures. ♦ Provider barriers and collection of feedback on IEHP quality processes and support. ♦ Recommendations and provision of education, training, resources, and follow-up. IEHP also made provider roster enhancements to ensure information shared is in a format that can be easily inserted into current office workflows. This tool allows providers to see the status of members' progress toward completing all needed preventive health visits, along with dates of services associated with key clinically recommended milestones. Prospective preventive care rosters were also developed and made available through the IEHP provider portal. This reporting tool provides an additional level of detail, ensuring that providers can view any needed preventive screenings as soon as a member is assigned to the MCP and/or the provider's panel. Provider learning modules are available on the IEHP website. These learning modules are

2022–23 External Quality Review Recommendations Directed to IEHP	Actions Taken by IEHP to Address the External Quality Review Recommendations
	designed to support providers and their office staff in becoming familiar with preventive screening recommendations, available tools/resources, and clinical best practices. Each module includes the following components: measure overview, keys to success, tools for practice improvement, tips for outreach and communication, and additional IEHP resources. Provider learning modules are currently available for the following measures: ♦ *Child and Adolescent Well-Care Visits—Total* ♦ *Childhood Immunization Status—Combination 10* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Well-Child Visits in the First 30 Months of Life* **Data Capture Improvements** In September 2023, IEHP implemented enhancements to the family link data methodology workflows and observed an increase in the number of family link matches across the early childhood measure denominators. Based on intervention evaluation results, IEHP is continuing with all activities described above in 2024. In measurement year 2022, IEHP performed above the MPL for one measure out of the six measures included within the Children's Health domain (17 percent). In comparison, IEHP has performed above the MPLs for four of the six measures within the Children's Health domain in measurement year 2023 (67 percent). IEHP quality improvement efforts for the Children's Health domain measures resulted in an overall Children's Health domain raw percentage rate improvement of 50 percent. In measurement year 2023, the cancer screening improvement activities described above also resulted in IEHP meeting the MPL for the *Cervical Cancer Screening* measure.

Assessment of IEHP's Self-Reported Actions

HSAG reviewed IEHP's self-reported actions in Table C.14 and determined that IEHP adequately addressed the 2022–23 EQR recommendations. IEHP indicated that all findings from DHCS' most recent compliance review scoring process were from DHCS' Medical Audit of the MCP. IEHP noted that the MCP resolved all findings and that DHCS closed the CAP.

IEHP indicated that the MCP conducted root cause analyses for measures with rates below the MPLs in measurement year 2022 to identify the factors that may have contributed to the MCP's performance below the MPLs. Based on the analyses, IEHP implemented the following strategies:

- Increased member incentives.
- Expanded member engagement/outreach activities to include help with appointment scheduling.
- Increased provider incentives.
- Expanded provider education/training and support activities.
- Enhanced data capture processes.

The interventions IEHP implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023:

- *Cervical Cancer Screening*
- *Child and Adolescent Well-Care Visits—Total*
- *Immunizations for Adolescents—Combination 2*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for IEHP

Based on the overall assessment of IEHP's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of IEHP's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to IEHP's 2023 and 2024 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of each PIP.
- The HSAG auditor determined that IEHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2023.
- IEHP performed above the HPL in measurement year 2023 for the *Chlamydia Screening in Women—Total* measure.
- IEHP reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for IEHP show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, HSAG identified no specific opportunities for improvement related to the data collection and management processes IEHP had in place to inform network adequacy standard and indicator calculations and noted that IEHP:
  - Had robust procedures in place for validating members who are geocoded, such as running spatial analysis, which cleanses data to ensure the member was reported in the correct ZIP Code.
  - Conducted multiple discrepancy checks daily and generated reporting on member data to ensure there were no observed discrepancies.

Opportunities for Improvement

- IEHP did not properly incorporate the DHCS historical pharmacy data as supplemental data into its performance measure rate production process.
- IEHP performed below the MPLs in measurement year 2023 for the following three of 18 measure rates that HSAG compared to benchmarks (17 percent):
  - *Asthma Medication Ratio—Total*
  - *Childhood Immunization Status—Combination 10*
  - *Lead Screening in Children*
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for IEHP:
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Practice Guidelines—§438.236

2023–24 External Quality Review Recommendations

- Update the pharmacy data files to ensure that the DHCS historical pharmacy data file is separate from the carved-out pharmacy data received from Magellan and is incorporated as supplemental data for performance measure reporting.
- For measures for which IEHP performed below the MPLs in measurement year 2023, identify the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, IEHP should determine whether the member-, provider-, and data capture improvement-focused interventions described in Table C.14 need to be revised or abandoned based on intervention evaluation results.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure IEHP meets all CFR standard requirements moving forward:
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Practice Guidelines—§438.236

IEHP's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of IEHP as well as the plan's progress with addressing these recommendations.

Kaiser Permanente

Prior to January 1, 2024, DHCS held separate contracts with Kaiser NorCal and Kaiser SoCal. Beginning January 1, 2024, DHCS contracted with Kaiser Permanente under one contract that includes all counties previously served by Kaiser NorCal and Kaiser SoCal and an additional 27 counties. See Table 1.1 in Section 1 of *Volume 1 of 9* of this EQR technical report ("Introduction") for the list of Kaiser NorCal and Kaiser SoCal reporting units for measurement year 2023 performance measure-related activities and Table 1.2 for the list of Kaiser Permanente counties as of January 1, 2024.

In this section, HSAG displays information for Kaiser NorCal and Kaiser SoCal separately when the results were reported separately. For information that applies to the MCP based on the contract with DHCS that became effective January 1, 2024, HSAG presents the information as "Kaiser."

Follow-Up on Prior Year Recommendations—Kaiser NorCal

Table C.15 provides the 2022–23 EQR recommendations directed to Kaiser NorCal, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.15 to preserve the accuracy of Kaiser NorCal's self-reported actions.

Table C.15—Kaiser NorCal's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to Kaiser NorCal	Actions Taken by Kaiser NorCal to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Kaiser NorCal meets all CFR standard requirements moving forward.	Kaiser submitted responses for all corrective action findings to the DHCS Managed Care Quality and Monitoring Division (MCQMD). Kaiser provided monthly status updates to DHCS beginning June 2023 with evidence of remediation and/or additional clarification in response to DHCS' ongoing inquiries. MCQMD closed this audit on June 27, 2024.
2. Assess the factors that contributed to Kaiser NorCal performing below the MPLs in measurement year 2022 for the *Child and Adolescent Well-Care Visits—Total* and *Lead Screening in Children* measures and implement quality improvement strategies that target the	***Child and Adolescent Well-Care—Total*** Factors contributing to performance below the MPL in measurement year 2022: ♦ Appointment Accessibility

2022–23 External Quality Review Recommendations Directed to Kaiser NorCal	Actions Taken by Kaiser NorCal to Address the External Quality Review Recommendations
identified factors. As part of this assessment, Kaiser NorCal should determine whether the MCP's successful member outreach interventions described could be adapted to address the factors contributing to the MCP performing below the MPLs for these measures.	♦ Coronavirus disease 2019 (COVID-19) Impact: Reduced parent willingness to bring children for in-person visits. ♦ Age Transition Practice: Kaiser NorCal transitions members to adult and family medicine at age 18 years, while Medi-Cal considers patients to be pediatric up to age 21 years. Quality Improvement Strategies for the *Child and Adolescent Well-Care Visits—Total* measure: ♦ PDSA Initiatives: Implemented two PDSA cycles focusing on outreach to families with unscheduled well-child visits, resulting in the rate for this measure exceeding the MPL in measurement year 2023. ♦ Targeted Outreach and Missed Appointment Follow-ups: Made at minimum, two phone call attempts, followed by a certified letter. ♦ Implemented proactive scheduling for well-care visits while the patient was in the clinic for any appointment or service. ♦ Provider and Staff Education: Educated adult family medicine providers about DHCS' pediatric age guidelines and periodicity. ***Lead Screening in Children*** Factors contributing to performance below the MPL in measurement year 2022: ♦ Competing Priorities: The 12-month visit includes up to six vaccinations, which is a barrier to adding a blood draw. ♦ Separate Lab Visit Requirement: The need for a separate visit to the lab for lead screening discourages follow-through.

2022–23 External Quality Review Recommendations Directed to Kaiser NorCal	Actions Taken by Kaiser NorCal to Address the External Quality Review Recommendations
	♦ Phlebotomy Wait Times: Significant wait times, especially during peak hours, deterred parents/guardians from bringing children in for screenings. ♦ Parental Hesitancy: Parents/guardians were hesitant due to long wait times and competing interventions. Quality Improvement Strategies for the *Lead Screening in Children* measure: ♦ Regional Outreach: Launched a new regional outreach program for blood lead screening in 2024. ♦ EHR Technology Solutions: Implemented care gap alerts, best practice alerts, and automatically drafted orders to prompt providers before and during visits. ♦ Enhanced Lab Access: Established convenient drop-in lab hours, including evenings and weekends. ♦ In-Room Blood Draws: Introduced blood draws in exam rooms to improve convenience. ♦ Patient Education: Included lead screening information in the after-visit summary for well-care visits.

Assessment of Kaiser NorCal's Self-Reported Actions

HSAG reviewed Kaiser NorCal's self-reported actions in Table C.15 and determined that Kaiser NorCal adequately addressed the 2022–23 EQR recommendations. Kaiser NorCal indicated that the MCP worked with DHCS to fully resolve all findings from DHCS' most recent compliance review scoring process and that based on information the MCP submitted to DHCS, DHCS closed the audit on June 27, 2024.

Kaiser NorCal noted the factors contributing to the MCP performing below the MPLs for the *Child and Adolescent Well-Care Visits—Total* and *Lead Screening in Children* measures in measurement year 2022. To address these factors, Kaiser NorCal reported implementing member- and provider-focused interventions, including:

- Conducted member outreach to families with children needing to schedule their well-child visits.
- Conducted provider and member education.
- Launched a new regional member outreach program for blood lead screening.
- Implemented alerts in the EHR system to improve blood lead screening.

The interventions Kaiser NorCal implemented may have contributed to the rate for the *Child and Adolescent Well-Care Visits—Total* measure moving from below the MPL in measurement year 2022 to above the MPL in measurement year 2023.

Follow-Up on Prior Year Recommendations—Kaiser SoCal

Table C.16 provides the 2022–23 EQR recommendations directed to Kaiser SoCal, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.16 to preserve the accuracy of Kaiser SoCal's self-reported actions.

Table C.16—Kaiser SoCal's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to Kaiser SoCal	Actions Taken by Kaiser SoCal to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Kaiser SoCal meets all CFR standard requirements moving forward.	Kaiser submitted responses for all corrective action findings to the DHCS MCQMD. Kaiser provided monthly status updates to DHCS beginning June 2023 with evidence of remediation and/or additional clarification in response to DHCS' ongoing inquiries. MCQMD closed this audit on June 27, 2024.
2. Assess the factors that contributed to Kaiser SoCal performing below the MPLs in measurement year 2022 for the *Child and Adolescent Well-Care Visits—Total* and *Lead Screening in Children* measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Kaiser SoCal should determine whether the MCP's successful member- and provider-focused interventions could be adapted to address the factors contributing to the	Kaiser SoCal engaged with Kaiser San Diego and its regional stakeholders to proactively address Kaiser SoCal's performance below the MPLs for the *Child and Adolescent Well-Care Visits—Total* and *Lead Screening in Children* measures in MY 2022. The health care team uses the EHR Health Connect to leverage technology and workflow tools, like proactive office encounter workflows, care gap alerts, outreach, and panel management tools. In addition, Kaiser SoCal is currently conducting a DHCS Quality Improvement and Health Equity Lean A3 Project from May through August

2022–23 External Quality Review Recommendations Directed to Kaiser SoCal	Actions Taken by Kaiser SoCal to Address the External Quality Review Recommendations
MCP performing below the MPLs for these measures.	2024, targeting performance on both measures. One of the factors contributing to Kaiser SoCal performing below the MPL for the *Child and Adolescent Well-Care Visits—Total* measure was that the MPL benchmark increased by 3.62 percentage points from measurement year 2021 to measurement year 2022. In addition, a national, state, and San Diego County surge of respiratory syncytial virus and other respiratory illnesses occurred during October through December 2022, which resulted in an increased sick child appointment demand. This required Kaiser SoCal to pause well-child visit outreach and appointment scheduling to preserve appointment access for sick members. Kaiser SoCal's performance on the *Child and Adolescent Well-Care Visits—Total* measure improved by more than 8 percentage points from measurement year 2020 to measurement year 2022, which was largely attributed to 2020–22 PIP interventions. *Child and Adolescent Well-Care Visits—Total* measure interventions include the following: ♦ Sending regional well-care visit reminder letters for members 3 and 6 years of age. ♦ Sending care gap alerts regionwide to providers during office visits and to call center staff members for pediatric members 3 to 17 years of age who have not completed a well-child in the past 12 months. ♦ Expanding care gap alerts to adult primary care for the 18–21-year-old age group.

2022–23 External Quality Review Recommendations Directed to Kaiser SoCal	Actions Taken by Kaiser SoCal to Address the External Quality Review Recommendations
	♦ Implementing the KP.org member portal online personal action plan reminder for members 18 to 21 years of age. ♦ Grouping to schedule an annual visit with their provider. Kaiser SoCal's performance on the *Lead Screening in Children* measure decreased significantly by over 15 percentage points from measurement year 2019 to measurement year 2022, during the COVID-19 pandemic. Parents' willingness to bring their children in for a lab draw was identified as an ongoing key barrier. Focused interventions include the following: ♦ Implemented 2023 capillary test pilot and education to increase provider and staff engagement at two high-volume San Diego pediatric clinics. Kaiser SoCal adopted the interventions and expanded the interventions to other San Diego pediatric clinics during Q1 and Q2 2024. ♦ Revised the *Lead Screening in Children* measure care gap inclusion criteria to target Medi-Cal members ages 9 months to 24 months. ♦ Continued the established automated complete care regional blood lab order and parent letter informing them of the importance of bringing their child in for a lead lab test. ♦ Changed blood lead screening orders to STAT to decrease parent wait time when they present to the lab. Kaiser SoCal's measurement year 2023 rates for the *Child and Adolescent Well-Care Visits—Total* and *Lead Screening in Children* measures remain below the MPLs. Kaiser

2022–23 External Quality Review Recommendations Directed to Kaiser SoCal	Actions Taken by Kaiser SoCal to Address the External Quality Review Recommendations
	SoCal's tracking of internal measurement year 2024 data shows improved performance for both measures.

Assessment of Kaiser SoCal's Self-Reported Actions

HSAG reviewed Kaiser SoCal's self-reported actions in Table C.16 and determined that Kaiser SoCal adequately addressed the 2022–23 EQR recommendations. Kaiser SoCal indicated that the MCP worked with DHCS to fully resolve all findings from DHCS' most recent compliance review scoring process and that based on information the MCP submitted to DHCS, DHCS closed the audit on June 27, 2024.

Kaiser SoCal noted the factors contributing to the MCP performing below the MPLs for the *Child and Adolescent Well-Care Visits—Total* and *Lead Screening in Children* measures in measurement year 2022. To address these factors, Kaiser SoCal reported implementing member- and provider-focused interventions, including:

- Sent well-care visit reminder letters for members 3 and 6 years of age.
- Disseminated care gap alerts to providers for members who have not completed their well-child visits.
- Piloted a provider capillary testing and education intervention that resulted in the MCP adopting and expanding the interventions.
- Changed blood lead screening orders to STAT to decrease parent wait time at the lab.

While the rates for the *Child and Adolescent Well-Care Visits—Total* and *Lead Screening in Children* measures remained below the MPLs in measurement year 2023, Kaiser SoCal noted that internal tracking of measurement year 2024 data shows improved performance for both measures.

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Kaiser

Based on the overall assessment of Kaiser's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Kaiser's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When

applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths—Kaiser NorCal

- The HSAG auditor determined that Kaiser NorCal followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- Kaiser NorCal performed above the HPLs for the following measures in measurement year 2023:
  - *Asthma Medication Ratio—Total*
  - *Breast Cancer Screening—Total*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status—Combination 10*
  - *Chlamydia Screening in Women—Total*
  - *Controlling High Blood Pressure—Total*
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - *Immunizations for Adolescents—Combination 2*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- Kaiser NorCal reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.

Opportunities for Improvement—Kaiser NorCal

- Kaiser NorCal performed below the MPLs in measurement year 2023 for the following two of 18 measure rates that HSAG compared to benchmarks (11 percent):
  - *Lead Screening in Children*
  - *Topical Fluoride for Children—Dental or Oral Health Services—Total*

Strengths—Kaiser SoCal

- The HSAG auditor determined that Kaiser SoCal followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.

- Kaiser SoCal performed above the HPLs for the following measures in measurement year 2023:
  - *Asthma Medication Ratio—Total*
  - *Breast Cancer Screening—Total*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status—Combination 10*
  - *Controlling High Blood Pressure—Total*
  - *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - *Immunizations for Adolescents—Combination 2*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- Kaiser SoCal reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.

Opportunities for Improvement—Kaiser SoCal

- Kaiser SoCal performed below the MPLs in measurement year 2023 for the following two of 18 measure rates that HSAG compared to benchmarks (11 percent):
  - *Child and Adolescent Well-Care Visits—Total*
  - *Lead Screening in Children*

Strengths—Kaiser

- HSAG assigned *High Confidence* levels to Kaiser's 2023 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in the Design stage of each PIP.
- HSAG assigned a *High Confidence* level to Kaiser's 2024 clinical PIP submission, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of its clinical PIP.
- DHCS' 2024 compliance review scores for Kaiser show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, Kaiser demonstrated streamlined processes for receipt of member and provider enrollment files, which were directly integrated into Kaiser's data warehouse for reporting network adequacy. This process centralized data ingestion and reporting activities. Additionally, HSAG identified no specific opportunities for improvement related to the data collection and management processes Kaiser had in place to inform network adequacy standard and indicator calculations.

Opportunities for Improvement—Kaiser

- HSAG's 2024 PIP validation determined that Kaiser failed to include all required details of its PIP processes for its nonclinical PIP.
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for Kaiser:
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Practice Guidelines—§438.236
  - Quality Assessment and Performance Improvement Program—§438.330

2023–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure Kaiser includes all required information in the MCP's 2025 annual nonclinical PIP submission.
- Based on the audited performance measure rates changing from reporting unit level in measurement year 2023 to plan level in measurement year 2024, and the counties in which the MCP operates changing as of January 1, 2024, Kaiser should assess measurement year 2023 performance to determine priority areas for improvement. The MCP should continue implementing interventions that have resulted in positive outcomes and identify new quality improvement strategies as applicable to address factors affecting performance.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure Kaiser meets all CFR standard requirements moving forward:
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Practice Guidelines—§438.236
  - Quality Assessment and Performance Improvement Program—§438.330

Kaiser's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of Kaiser as well as the plan's progress with addressing these recommendations.

Kern Family Health Care

Follow-Up on Prior Year Recommendations

Table C.17 provides the 2022–23 EQR recommendations directed to KHS, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.17 to preserve the accuracy of KHS' self-reported actions.

Table C.17—KHS' Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to KHS	Actions Taken by KHS to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure KHS meets all CFR standard requirements moving forward.	♦ The 2022 DHCS audit findings impacted KHS' scores for eight of 14 CFR scores. ♦ KHS submitted our CAP to DHCS on June 8, 2023, which included a total of 93 specific actions to address and rectify the findings. ♦ Corrective actions included but were not limited to policy updates, desktop procedure and job aids updates, refresher trainings, report updates, and internal monitoring and auditing process improvements. ♦ KHS worked with DHCS to provide the appropriate supporting documentation to resolve the deficiencies, and DHCS closed the CAP as of April 19, 2024. ♦ The 2023 DHCS Medical Audit resulted in only one finding, which was closed by DHCS on June 5, 2024, further evidencing our successful resolution of the previous deficiencies impacting the 2022 CFR scoring and demonstrating our improved compliance with the CFR standard requirements.
2. For measures for which KHS performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified	♦ Developed a dedicated strike team in February 2023 focusing on initiatives to improve MCAS rates. The strike team consists of representatives from marketing/member engagement, business intelligence, provider network management, and quality performance.

2022–23 External Quality Review Recommendations Directed to KHS	Actions Taken by KHS to Address the External Quality Review Recommendations
factors. As part of this assessment, KHS should determine whether the MCP's member-, provider-, and system-focused interventions for those measures that remained below the MPLs in measurement year 2022 need to be revised or abandoned based on intervention evaluation results.	♦ Developed key strategies to close gaps in care and monitored and analyzed outcomes for continual improvements. ♦ Created a member outreach team to contact members aging out of measures and schedule appointments for their preventive health services. Measures of focus included *Child and Adolescent Well-Care Visits—Total*, *Childhood Immunization Status—Combination 10*, *Immunizations for Adolescents—Combination 2*, *Lead Screening in Children*, and *Well-Child Visits in the First 30 Months of Life*. ♦ Partnered with the telehealth team to support follow-up appointment scheduling after emergency department visits for mental health and substance abuse disorders.

Assessment of KHS' Self-Reported Actions

HSAG reviewed KHS' self-reported actions in Table C.17 and determined that KHS adequately addressed the 2022–23 EQR recommendations.

KHS indicated that the MCP fully resolved the findings from DHCS' compliance review by implementing corrective actions, including:

- Updated policies, procedures, and job aids.
- Conducted refresher trainings.
- Updated reports.
- Improved internal monitoring and auditing processes.

KHS reported implementing the following strategies to improve performance on measures for which the MCP performed below the MPLs in measurement year 2022, including:

- Developed a multidisciplinary team to focus on initiatives to improve performance measure rates.
- Developed strategies to close gaps in care and monitored outcomes to ensure continuous quality improvement.
- Created a member outreach team to contact members and schedule appointments for preventive health services.

- Coordinated internally to support scheduling follow-up appointments for members with substance use and other mental health disorders who are seen in the emergency department.

The strategies KHS implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023:

- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Total*

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for KHS

Based on the overall assessment of KHS' delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of KHS' activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to KHS' 2023 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in the Design stage of each PIP.
- The HSAG auditor determined that KHS followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- KHS performed above the HPL in measurement year 2023 for the *Prenatal and Postpartum Care—Postpartum Care* measure.
- KHS reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for KHS show that the MCP was fully compliant with all CFR standards.
- During the NAV audit process, HSAG noted that KHS implemented an audit process to review member counts at each stage of data extraction from multiple sources, ensuring accuracy and consistency in member enrollment data. Additionally, HSAG identified no specific opportunities for improvement related to the data collection and management

processes KHS had in place to inform network adequacy standard and indicator calculations.

Opportunities for Improvement

- HSAG's 2024 PIP validation determined that KHS failed to include all required details of its PIP processes for both clinical and nonclinical PIPs.
- KHS performed below the MPLs in measurement year 2023 for the following 10 of 18 measure rates that HSAG compared to benchmarks (56 percent):
  - *Child and Adolescent Well-Care Visits—Total*
  - *Childhood Immunization Status—Combination 10*
  - *Developmental Screening in the First Three Years of Life—Total*
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
  - *Immunizations for Adolescents—Combination 2*
  - *Lead Screening in Children*
  - *Topical Fluoride for Children—Dental or Oral Health Services—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

2023–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure KHS includes all required information in the MCP's 2025 annual clinical and nonclinical PIP submissions.
- For measures for which KHS performed below the MPLs in measurement year 2023, identify the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, KHS should determine whether the interventions described in Table C.17 need to be revised or abandoned based on intervention evaluation results.

KHS' responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of KHS as well as the plan's progress with addressing these recommendations.

L.A. Care Health Plan

Follow-Up on Prior Year Recommendations

Table C.18 provides the 2022–23 EQR recommendations directed to L.A. Care, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.18 to preserve the accuracy of L.A. Care's self-reported actions.

Table C.18—L.A. Care's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to L.A. Care	Actions Taken by L.A. Care to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure L.A. Care meets all CFR standard requirements moving forward.	L.A. Care has worked with DHCS through the 2022–23 DHCS Medical Audit CAP process to resolve the identified findings from DHCS' compliance review scoring process to ensure L.A. Care meets all CFR standard requirements moving forward. **Coordination and Continuity of Care** ♦ Added a distinct field to the MCP's annual audit tools to capture anticipatory guidance, divide all components (e.g., separate mental and physical health histories), and drill down on screenings (e.g., blood lead screening and immunizations). ■ Updated the audit scoring methodology with new fields based on APL 22-030. ■ Enhanced IHA Due Monthly Reports process to include a monthly IHA Noncompliance Report of all overdue IHAs per PPG to be delivered through the provider portal. ■ Sent annual attestations for all PPGs and direct network providers to ensure IHA completion within the required 120-day time frame for new Medi-Cal members.

2022–23 External Quality Review Recommendations Directed to L.A. Care	Actions Taken by L.A. Care to Address the External Quality Review Recommendations
	♦ Updated the IHA annual audit tool and IHA monitoring tool to include oversight and monitoring of medical records to ensure anticipatory guidance for lead exposure is being provided to parents or guardians of age-appropriate members. The updated tools also ensure the provision of blood lead screening tests to child members at ages 1 and 2 years, including documentation of reasonable attempts to provide/schedule the test or documented voluntary refusal of the test. ■ Issued a provider communication with information about anticipatory guidance for lead exposure. The request for blood lead screening attestation will be annual. **Coverage and Authorization of Services** ♦ Implemented a poststabilization flag (i.e., priority) in the utilization management system SyntraNet to identify all poststabilization requests for the purpose of monitoring to ensure that cases are reviewed by qualified medical personnel. ■ Developed monthly/quarterly poststabilization monitoring reporting metrics for timeliness of decision making and compliance with decision making by the medical director for adverse determinations. ■ Presented poststabilization monitoring results to the MCP's internal utilization management leadership team and at the Utilization Management Committee (UMC) meetings. ♦ Developed a monthly tracking mechanism for specialty referrals that require prior authorization by L.A. Care's internal utilization management department. ■ Developed a monthly/quarterly report that includes an analysis and monitoring of

2022–23 External Quality Review Recommendations Directed to L.A. Care	Actions Taken by L.A. Care to Address the External Quality Review Recommendations
	specialty referrals, including but not limited to timeliness of decisions and notifications. ■ Presented the report results during the quarterly UMC meetings. ♦ Developed and implemented a process to analyze trends and detect over- and underutilization across the MCP. Each accountable L.A. Care department will track metrics within its domains and will report to the UMC, and over- and underutilization patterns will be presented during the quarterly UMC meetings. ■ Updated a utilization management policy to list the health services and quality improvement departments as accountable parties and included examples of service categories/types that may be included in the scope of monitoring. ■ Hired a utilization management clinical data analyst and community-based adult services (CBAS) utilization management nurses to support the MCP's processes for detecting and addressing over- and underutilization. ○ The utilization management clinical data analyst is tasked with supporting development of mechanisms for tracking and analyzing over- and underutilization trends. ○ CBAS utilization management nurses will be tasked with conducting utilization management review for CBAS and decreasing auto-approvals. ♦ Conducted training to clinical audit staff members on utilization management regulatory program standards, including prior authorization review criteria and notification of providers. Moving forward, the training will be conducted with new and existing clinical audit staff.

2022–23 External Quality Review Recommendations Directed to L.A. Care	Actions Taken by L.A. Care to Address the External Quality Review Recommendations
	■ Provided oversight of workflow updates concerning eConsult as related to utilization management and prior authorization requirements as well as utilization management functions. ■ Conducted an audit of a delegated entity's new utilization management process, prior authorization review criteria, and notification samples once the entity made improvements to be compliant with utilization management regulatory requirements. ■ Provided oversight of the development of utilization management program materials, including website member appeals and grievance rights language, NOA template guidance for a delegated entity's template revisions, and the Utilization Management Member Approval Letter template. **Provider Selection** ♦ Developed and implemented a PCP on-demand training module. The training module gives new providers the flexibility to access the training module via the L.A. Care University portal. ■ Created a workflow for new providers to complete the training prior to opening their panels. ○ The workflow will increase the time for providers to complete their onboarding training. ○ Providers will have increased choices for when and how to take the training. ○ On-demand training allows providers to take their training online whenever time permits.

2022–23 External Quality Review Recommendations Directed to L.A. Care	Actions Taken by L.A. Care to Address the External Quality Review Recommendations
	▪ Scheduled dates and times for instructor-led trainings for providers who wish to interact directly with an instructor. ▪ The external learning team enhanced its monitoring and escalation process. **Grievance and Appeal Systems** ♦ Updated a desk-level procedure to include the updated Authorized Representative Designation/Appointment of Representative (ARD/AOR) regulation and guidelines. ▪ Conducted an ARD/AOR training for appeals and grievances staff members. ▪ Updated the Audit Scorecard to include ARD/AOR validation for all appeals and grievances staff members who process cases. ▪ The appeals and grievances quality auditing team conducts internal monitoring and oversight to ensure the process was trained effectively and the team is following the correct process. ▪ The appeals and grievances quality auditing team provides emerging trends and audit results to L.A. Care's Internal Compliance Committee. **Subcontractual Relationships and Delegation** ♦ Implemented an annual attestation process during Q4 2022. This process requires subcontractors to attest that no ownership and control changes took place during the calendar year or to disclose any ownership changes for which L.A Care was not previously notified. The attestation process takes place annually in December. ♦ Developed a desktop procedure document that encompasses all aspects of the MCP's ownership and control notification

2022–23 External Quality Review Recommendations Directed to L.A. Care	Actions Taken by L.A. Care to Address the External Quality Review Recommendations
	responsibilities, inclusive of reporting of subcontractor noncompliance to DHCS within 10 business days of discovery per the notification timelines as detailed in APL 23-006. **Enrollee Rights** ♦ Updated a desk-level procedure to include quality of care (QOC) and quality of service definitions and a section on how to identify QOC and quality of service grievances. ■ Updated the potential quality improvement process to assist staff members with correctly identifying and processing QOC concerns. ■ Conducted a refresher training to instruct staff members on how to identify potential quality improvement cases and how to identify and classify quality of service and QOC cases. ■ Expanded ongoing monitoring of the classification of cases at the specialist and coordinator levels and incorporated the classification into the monitoring scorecard. ♦ Hired a dedicated appeals and grievances medical director to review and level QOC cases. ♦ Added additional appeals and grievances staff members to meet the appeals and grievances key performance indicators. ♦ Hired a dedicated trainer for the appeals and grievances team to create and administer effective trainings for staff members. ♦ Conducted provider information request (PIR) training to instruct staff members on how to process and send the PIR to the internal and external business partner(s) requesting a response to the grievance allegation.

2022–23 External Quality Review Recommendations Directed to L.A. Care	Actions Taken by L.A. Care to Address the External Quality Review Recommendations
	▪ Created a desk-level procedure intake escalation process for PIRs. ♦ Developed productivity reports and enhanced current reporting to encompass a view of open inventory and case status. ▪ The appeals and grievances audit team implemented an enhanced audit program consisting of back-end auditing of all case types, and focused on the completeness, accuracy, and timely processing of resolution letters. ♦ The appeals and grievances team also created extension letter templates and configuration into the grievance system. ▪ The extension letters will be sent to members advising that the case resolution will exceed 30 days. ♦ Conducted appeals and grievances case classification training to ensure that all members' issues are identified and addressed. ♦ The appeals and grievances staff members provided a refresher training on the appropriate construction of resolution letters. ▪ Ongoing refresher training will take place as needed, based on monitoring/auditing results. ▪ The appeals and grievances team created and conducted letter writing workshops inclusive of a complete investigation, fully addressing the member's concern, and writing clear and concise letters. ♦ Updated a desk-level procedure to include the updated ARD/AOR regulation and guidelines. **Appeals and Grievances** ♦ The quality assurance audit team updated scorecards to include scoring elements for

2022–23 External Quality Review Recommendations Directed to L.A. Care	Actions Taken by L.A. Care to Address the External Quality Review Recommendations
	clear and concise wording on resolution letters, PIR completeness (fully investigating and addressing the member's concerns), and case classification (correctly identifying and classifying quality of service and QOC cases). ♦ The appeals and grievances quality auditing team conducts internal monitoring and oversight to ensure the process was trained effectively and the team is following the correct process, and provides emerging trends to the Internal Compliance Committee.
2. For measures for which L.A. Care performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, L.A. Care should determine whether the MCP's member- and provider-focused interventions to improve well-child visit rates need to be revised or abandoned based on intervention evaluation results.	For measurement year 2022, L.A. Care performed below the MPLs for the following measures: ♦ *Cervical Cancer Screening* ♦ *Child and Adolescent Well-Care Visits—Total* ♦ *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* ♦ *Lead Screening in Children* ♦ Both *Well-Child Visits in the First 30 Months of Life* measures Factors that affected our performance overall were: ♦ Access to Care—Appointment availability was limited for members due to lack of specialty care or limited appointment slots for cervical cancer screenings, well-care visits, and well-child visits. ♦ Data Issues—For the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* and *Child and Adolescent Well-Care Visits—Total* measures, there was a disconnect between National Provider Identifier and specialty mapping. Specialists were not mapped correctly to identify a behavioral health provider or PCPs for the encounters to close care gaps.

2022–23 External Quality Review Recommendations Directed to L.A. Care	Actions Taken by L.A. Care to Address the External Quality Review Recommendations
	♦ Member Motivation and Education—Members did not feel the need to see a provider or specialist for preventive care services such as well-care visits, blood lead screenings, and cervical cancer screenings. Additionally, some members were unaware that they needed to see a provider or were unwilling to see a provider after being in the emergency department for mental illness. Strategies implemented to address these factors: ♦ Additional Member Touchpoints—In 2023 and 2024, implemented social media campaigns, member incentives (see below), member feedback surveys, and live-agent calls for feedback and outreach. ■ These additional member touchpoints have a more tailored and targeted approach, aimed at getting members back to care, continuing to spread awareness, and understanding barriers in accessing care. ♦ Member Incentives—Started an incentive for well-child visits in fall 2023 and continued this incentive in 2024. An incentive for cervical cancer screenings is actively being planned to launch in 2025. A potential incentive related to the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure is being discussed. ♦ Monthly Joint Operation Meetings with IPAs/ Medical Groups—Meet with large provider groups where cervical cancer screening is a standing item on the agenda. These meetings involve deep dives into challenges, root causes, and future planning for cervical cancer screenings and other priority measures. ♦ Data Reconciliation—For all measures with low rates, L.A. Care conducted a Q4 push with IPAs to collect any missing encounters for

2022–23 External Quality Review Recommendations Directed to L.A. Care	Actions Taken by L.A. Care to Address the External Quality Review Recommendations
	measurement year 2023. For the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure, this involved identifying specialty providers to close care gaps with behavioral health programs. Data analysts also continued to address ongoing data ingestion issues from the State. In addition, provider groups became more open to address data discrepancies that they were encountering, such as with well-care visits. ♦ Provider Touchpoints—Conducted continuing medical education events in 2023 and 2024 for blood lead and cervical cancer screenings, with an upcoming continuing medical education event in summer 2024 that will include a well-child visits presentation. For the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure, a new quality improvement project is focusing on the process of providing timely notifications to PCPs of patients seen in the emergency department for mental health concerns and who need a follow-up. Lastly, blood lead screening attestations were sent in 2023 to reaffirm providers' commitments to blood lead screening procedures. L.A. Care has no plans to abandon well-child visit interventions, based on evaluation results. Measurement years 2022 and 2023 outcome results are limited, but available results and feedback show that some of the member touchpoints (social media and text messages) reach a high percentage of members and are well-received. Outcome results for automated reminder calls have been shown to be successful, and L.A. Care will therefore continue these calls. The well-child visit report has received positive feedback from some IPAs/medical groups and plan partners. Additional nursing staff has allowed

2022–23 External Quality Review Recommendations Directed to L.A. Care	Actions Taken by L.A. Care to Address the External Quality Review Recommendations
	L.A. Care to expand quality improvement efforts with provider offices, IPAs/medical groups, and other L.A. Care teams.

Assessment of L.A. Care's Self-Reported Actions

HSAG reviewed L.A. Care's self-reported actions in Table C.18 and determined that L.A. Care adequately addressed the 2022–23 EQR recommendations.

L.A. Care described in detail the steps it took to fully resolve all findings from DHCS' most recent compliance review scoring process and ensure the MCP meets all CFR standard requirements moving forward. Actions included revising existing policies, procedures, and tools; developing and implementing new processes; and hiring new staff members.

For measures with rates below the MPLs in measurement year 2022, L.A. Care summarized the factors that may have contributed to the MCP's performance below the MPLs. L.A. Care described in detail member- and provider-focused interventions the MCP implemented to address the identified factors, including:

- Expanded member outreach efforts to include additional member touchpoints.
- Initiated a new member incentive program for well-child visits.
- Conducted monthly meetings with large provider groups and included cervical cancer screening as a standing agenda item.
- Conducted provider education.

The interventions L.A. Care implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023:

- *Child and Adolescent Well-Care Visits—Total*
- *Lead Screening in Children*

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for L.A. Care

Based on the overall assessment of L.A. Care's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for

improvement, and recommendations for the plan. Note that all of L.A. Care's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to L.A. Care's 2023 and 2024 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of each PIP.
- The HSAG auditor determined that L.A. Care followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- L.A. Care performed above the HPLs for the following measures in measurement year 2023:
  - *Chlamydia Screening in Women—Total*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- DHCS' 2024 compliance review scores for L.A. Care show that the MCP was fully compliant with five of the 14 CFR standards.
- During the NAV audit process, L.A. Care demonstrated the ability to maintain accurate and complete provide information through an attestation process with its provider network. Additionally, HSAG identified no specific opportunities for improvement related to the data collection and management processes L.A. Care had in place to inform network adequacy standard and indicator calculations.

Opportunities for Improvement

- L.A. Care performed below the MPLs in measurement year 2023 for the following seven of 18 measure rates that HSAG compared to benchmarks (39 percent):
  - *Asthma Medication Ratio—Total*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status—Combination 10*
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- L.A. Care has remaining findings to resolve from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.

- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for L.A. Care:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Provider Selection—§438.214
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100

2023–24 External Quality Review Recommendations

- For measures for which L.A. Care performed below the MPLs in measurement year 2023, identify the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, L.A. Care should determine whether the member- and provider-focused interventions described in Table C.18 need to be revised or abandoned based on intervention evaluation results.
- Work with DHCS to fully resolve the findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure L.A. Care meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Provider Selection—§438.214
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100

L.A. Care's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of L.A. Care as well as the plan's progress with addressing these recommendations.

Molina Healthcare of California

Follow-Up on Prior Year Recommendations

Table C.19 provides the 2022–23 EQR recommendations directed to Molina, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.19 to preserve the accuracy of Molina's self-reported actions.

Table C.19—Molina's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to Molina	Actions Taken by Molina to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Molina meets all CFR standard requirements moving forward.	Molina worked with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Molina meets all CFR standard requirements moving forward. A summary of corrective actions taken to resolve all findings was submitted to DHCS on September 18, 2023. The CAP response was reviewed by DHCS, and DHCS closed the CAP on December 1, 2023.
2. For measures for which Molina performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Molina should determine whether the MCP's interventions need to be revised or abandoned based on intervention evaluation results. a. Based on measurement year 2022 performance measure results, Molina should prioritize implementing quality improvement strategies in Riverside/San Bernardino counties.	Molina conducted MCP-, member-, and provider-focused, county-specific Ishikawa diagram causal and barrier analyses for all performance measures with rates that fell below the MPLs in measurement year 2022 to identify factors that affected Molina's performance on these measures. Molina implemented quality improvement strategies that targeted the identified factors. Potential factors were grouped under the categories of outreach, health disparities, data, access, IPA/provider engagement, and member engagement. Based on the county-specific priorities identified, Molina developed strategies to target the identified factors for prenatal and postpartum care, pediatric

2022–23 External Quality Review Recommendations Directed to Molina	Actions Taken by Molina to Address the External Quality Review Recommendations
	health, and women's health cancer screenings. <u>Riverside/San Bernardino Counties</u> Identified Factors for Improvement: ♦ Member Engagement: Historically members who are not using available prenatal support services. ♦ Provider Engagement: Low collaboration between community-based partners and provider groups ♦ Data: Missing/incomplete encounter data submissions. Strategies: Focus—Prenatal and Postpartum Care ♦ Developed a plan for how to improve early pregnancy identification. ♦ Created a plan to expand mobile solutions for both prenatal and postpartum care. ♦ Enhanced culturally tailored outreach efforts to improve member education about the importance of receiving timely maternal health care. Previous 2022–23 interventions status: ♦ Molina's partnership with the contracted vendor, Lucina, to find pregnant members within the first trimester is ongoing and is now built into Molina's data capture workflow. ♦ Molina has contracted with Ouma, a telehealth obstetrics/gynecology (OB/GYN)/maternal fetal medicine provider group to assist with completing timely prenatal and postpartum visits, to support members living in rural communities.

2022–23 External Quality Review Recommendations Directed to Molina	Actions Taken by Molina to Address the External Quality Review Recommendations
	♦ Molina's maternal health outreach team continues to add the vendor-identified pregnancies into its outreach targets lists and track prenatal appointments scheduled and referrals to doulas and local programs such as Mamas y Bebes, Black Infant Health, and Ouma. ♦ Molina's practice transformation team is expanding its visit strategy to target OB/GYNs. ♦ Molina's diaper voucher mailer program is ongoing for moms who had a delivery. <u>Sacramento County</u> Identified Factors for Improvement: ♦ Member Engagement: Historically unengaged members who are not completing cancer screenings. ♦ Data: Missing/incomplete encounter data submissions. ♦ Provider Engagement: Lack of provider collaboration with Molina's mobile/alternative access opportunities. Strategies: Focus—Women's Health—Cancer Screenings ♦ Developed a plan to expand access to services through mobile clinic days and drop trailers through collaboration with provider partners. ♦ Engaged providers to identify opportunities to share resources to improve member outreach efforts for historically noncompliant members. ♦ Increased the accuracy of encounter data submission by developing an encounter reconciliation process.

2022–23 External Quality Review Recommendations Directed to Molina	Actions Taken by Molina to Address the External Quality Review Recommendations
	Previous 2022–23 Interventions Status: ♦ Continued an ongoing data reconciliation process for all MCAS HEDIS measures. Supplemental data submissions are validated against encounter submissions to identify data inaccuracies and determine the root cause of the data gap. ♦ Expanded the Validation Scorecard to initiate solution planning and data submission monitoring to more groups, as needed. ♦ Discontinued the Member Engagement Award Program as the program did not yield the desired results. ♦ Continued to send participating providers lists of historically noncompliant members for breast cancer screenings, cervical cancer screenings, and well-child visits, and continued to offer provider incentives. <u>Imperial County</u> (Note that Molina's Medi-Cal contract in this county terminated December 31, 2024, with the DHCS 2024 MCP transition) Identified Factors for Improvement: ♦ Member Engagement: Historically unengaged members who do not complete annual well-care visits. ♦ Data: Missing/Incomplete encounter data submissions. ♦ Provider Engagement: Lack of provider collaboration on quality improvement-related efforts due to competing priorities of the COVID-19 public health emergency. Strategies: Focus—Pediatric Health ♦ Developed a provider education plan focused on improving encounter/claim

2022–23 External Quality Review Recommendations Directed to Molina	Actions Taken by Molina to Address the External Quality Review Recommendations
	submission effectiveness for closing HEDIS gaps. ♦ Increased provider engagement to improve the process for sharing resources to improve member outreach efforts for historically noncompliant members. ♦ Increased the accuracy of encounter data submissions by developing an encounter reconciliation process. Previous 2022–23 Interventions Status through December 31, 2023: ♦ Continued collaboration between Molina quality leadership and the Imperial County Physician Advisory Network to identify and adopt techniques for more effective communication of HEDIS measure change processes. The Imperial County Physician Advisory Network discussed how to increase pregnancy diagnosis notifications to Molina more efficiently using indicators on Molina's payer platform, Availity. ♦ Continued collaboration between Molina's health education department and medical directors to update the provider HEDIS Change Package educational materials to meet the needs of providers and ensure that materials were user friendly, actionable, and concise. ♦ Continued Molina's MCAS Change Communication education, and annually shared the measures that are newly held to the 50th percentile, any coding or technical specification changes, and tips for enhancing workflows to meet the measure requirements. ♦ Molina's practice transformation team continued to collaborate with providers to ensure that their key clinic stakeholders

2022–23 External Quality Review Recommendations Directed to Molina	Actions Taken by Molina to Address the External Quality Review Recommendations
	remained engaged with implementing needed changes. ♦ Discontinued the Member Engagement Award Program as it did not yield the desired results. ♦ Continued to send participating providers lists of historically noncompliant members for breast cancer screenings, cervical cancer screenings, and well-child visits, and continued to offer provider incentives. <u>Previous 2022–23 Interventions for All Counties</u> ♦ Molina's consent preference management team continued to collaborate with a contracted vendor to collect valid member contact information and preferred modalities, including email addresses. ♦ Continued to share updated member information with PCPs to improve the success of their preventive care outreach campaigns. ♦ Continued to email IHA reminders to members. ♦ Continued to require providers to assess members' need for preventive services and immunizations during the IHA. <u>New Interventions for 2024—Sacramento County</u> ♦ Expanded point-of-care gift cards for mammogram events. ♦ Sponsored mammogram events with WellSpace, collaborating on outreach, scheduling, and point-of-care gift cards.

2022–23 External Quality Review Recommendations Directed to Molina	Actions Taken by Molina to Address the External Quality Review Recommendations
	New 2024 Interventions for All Counties ♦ Implemented a pilot program that invites all African-American mothers into Molina's High-Risk OB program for closer monitoring. ♦ Added Molina Preventive Health Days to our One-Stop Help Centers, as we now have one open in each county (San Diego has two). ♦ Molina's health equity team revamped member incentive communications to include up to 10 languages (additional available on request). Responding to feedback from Molina's Community Advisory Committee, communications will include more pictures that reflect our diverse membership. ♦ Published the HEDIS Pocket Guide, as providers indicated this is the best way to have tips handy. ♦ Researched new vendors to help find accurate member contact information and leveraging community health workers to bring in members that have historically not had preventive services. ♦ Expanded Care Connections well-care visit targets, as we increased the nurse practitioner staffing to access more members at home.

Assessment of Molina's Self-Reported Actions

HSAG reviewed Molina's self-reported actions in Table C.19 and determined that Molina adequately addressed the 2022–23 EQR recommendations.

Molina indicated that it submitted to DHCS corrective actions the MCP took to resolve the findings from DHCS' compliance review. In response to Molina's corrective actions, DHCS closed the CAP on December 1, 2023.

To improve performance on measures for which Molina performed below the MPLs in measurement year 2022, the MCP indicated that it conducted MCP-, member-, and provider-focused, county-specific causal barrier analyses to identify the factors contributing to Molina's performance below the MPLs. Based on the identified factors, Molina developed county-specific strategies to improve performance related to prenatal and postpartum care, pediatric health, and women's cancer screenings, including:

- Riverside/San Bernardino Counties
  - Developed a plan for improving early pregnancy identification.
  - Expanded mobile solutions for both prenatal and postpartum care.
  - Enhanced culturally tailored outreach.
- Sacramento County
  - Partnered with providers to expand women's access to cancer screenings.
  - Engaged partners to identify opportunities to improve member outreach efforts for noncompliant members.
  - Developed an encounter data reconciliation process to improve encounter data accuracy.
- Imperial County
  - Developed a provider education plan to improve encounter/claim submission effectiveness.
  - Engaged partners to identify opportunities to improve member outreach efforts for noncompliant members.
  - Developed an encounter data reconciliation process to improve encounter data accuracy.

Molina also developed additional member- and provider-focused interventions across all counties to improve the MCP's performance.

The strategies and interventions Molina implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023:

- *Child and Adolescent Well-Care Visits—Total* for San Diego County
- *Controlling High Blood Pressure—Total* for Riverside/San Bernardino counties
- *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for Imperial County
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* for Imperial County

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Molina

Based on the overall assessment of Molina's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Molina's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to Molina's 2023 and 2024 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of each PIP.
- The HSAG auditor determined that Molina followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- Molina performed above the HPL in measurement year 2023 for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure for San Diego County.
- Molina reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for Molina show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, HSAG identified no specific opportunities for improvement related to the data collection and management processes Molina had in place to inform network adequacy standard and indicator calculations. During the audit process, Molina demonstrated the capability of:
  - Maintaining an adequate provider network to service its members which included comprehensive contracting, provider data maintenance, and monitoring and reporting methods. Molina addressed gaps in its network by submitting AAS requests to DHCS and increasing contracting efforts to fill network gaps.
  - Ensuring the accuracy of its provider network by conducting rigorous quality assurance measures which included conducting outbound call outreach to providers that did not attest during their quarterly cycle, conducting secret shopper surveys, and maintaining a rigorous quality assurance program which included daily audits of randomly selected provider data updates.

- Ensuring the accuracy of network adequacy indicator calculation and monitoring and reporting metrics by maintaining several multi-staffed quality assurance methods to verify accuracy of data.

Opportunities for Improvement

- Across all reporting units in measurement year 2023, Molina performed below the MPLs for 44 of the 71 measure rates that HSAG compared to benchmarks (62 percent).
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for Molina:
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228

2023–24 External Quality Review Recommendations

- Based on the audited performance measure rates changing from reporting unit level in measurement year 2023 to plan level in measurement year 2024, and the counties in which the MCP operates changing as of January 1, 2024, Molina should assess measurement year 2023 performance to determine priority areas for improvement. The MCP should continue implementing interventions that have resulted in positive outcomes and identify new quality improvement strategies as applicable to address factors affecting performance.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure Molina meets all CFR standard requirements moving forward:
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228

Molina's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of Molina as well as the plan's progress with addressing these recommendations.

Partnership HealthPlan of California

Follow-Up on Prior Year Recommendations

Table C.20 provides the 2022–23 EQR recommendations directed to Partnership, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.20 to preserve the accuracy of Partnership's self-reported actions.

Table C.20—Partnership's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to Partnership	Actions Taken by Partnership to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Partnership meets all CFR standard requirements moving forward.	In accordance with DHCS' advisement, the cited deficiencies for CFR compliance were derived from the annual DHCS Medical Audit conducted during calendar year 2022 and for which associated CAPs were accepted and closed in calendar year 2023. During this audit, Partnership was cited for deficiencies regarding blood lead screening, IHAs, and oversight of the Medi-Cal enrollment for transportation providers. Partnership continues to comply with the conditions of our CAPs closed as of October 2023.
2. For measures for which Partnership performed below the MPLs in measurement year 2022, assess the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Partnership should determine whether the MCP's member-, provider-, and community-focused interventions need to be revised or abandoned based on intervention evaluation results. a. Based on measurement year 2022 performance measure	Partnership's MCAS rates in measurement year 2022 continue to demonstrate the impact of workforce and infrastructure challenges on HEDIS outcomes. While the Southeast and Southwest regions made gains on legacy HEDIS measures such as *Breast Cancer Screening—Total*, *Cervical Cancer Screening*, *Childhood Immunization Status—Combination 10*, and *Immunizations for Adolescents—Combination 2*, the Northeast and Northwest regions continued to perform below the MPLs in measurement year 2022. One exception to this trend was the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure, for which both the Northeast and Northwest regions performed above the MPL. Notably, the Southeast Region performed below the MPL for the *Prenatal*

2022–23 External Quality Review Recommendations Directed to Partnership	Actions Taken by Partnership to Address the External Quality Review Recommendations
results, Partnership should prioritize implementing quality improvement strategies in the Northeast and Northwest regions.	*and Postpartum Care—Timeliness of Prenatal Care* measure, largely because of the loss of a large OB/GYN provider in the region. While providers throughout Partnership's network continue to struggle with workforce and infrastructure challenges, these issues are particularly prevalent in the Northeast and Northwest regions. Access to primary and specialty care remains the central barrier to completing preventive care services. PCP vacancies are especially pronounced in the Northeast and Northwest regions, where practices have challenges even securing locum appointments and PCP vacancy rates range from 12.50 to 43.85 percent across Partnership's 14 counties (2023). In response, in 2024 Partnership launched a robust provider recruitment and retention program throughout its provider network, offering signing bonuses paid over five years to a wide range of physicians, advanced practitioners, and behavioral health clinicians joining a practice in Partnership's network. Partnership also offers bonuses to clinicians who have completed 15 years of service within the network. These programs have been well received by the provider network and led to numerous vacancies being filled across the network. Given the popularity and results of the program, Partnership will continue to invest in its workforce development programs. Partnership has continued to facilitate internal workgroups dedicated to quality measure score improvement, given success in the prior year. In total, Partnership has the following five multi-functional workgroups dedicated to the various MCAS measure domains: ♦ Pediatrics ♦ Women's Health and Perinatal ♦ Medication Management

2022–23 External Quality Review Recommendations Directed to Partnership	Actions Taken by Partnership to Address the External Quality Review Recommendations
	♦ Chronic Diseases ♦ Behavioral Health Each workgroup works with representatives across the organization to identify high-value interventions using data and presents recommendations to executives to ensure alignment with organizational objectives. Several examples of efforts resulting from the Quality Measure Score Improvement workgroups include: ♦ A significant intervention aimed at improving lead screening rates among children involved the establishment of the Partnering for Pediatric Lead Prevention: A Point-of-Care Testing Initiative. This initiative provided point-of-care devices to clinical practices free-of-charge for 12 months, after which the practices would take ownership if they met testing benchmarks. The program targeted low-performing practices and those without current access to point-of-care testing, ensuring timely training and ongoing support. Initial rounds saw a significant uptake, with 26 point-of-care devices awarded in the second round, and plans for further expansion were underway. ♦ The School-Focused Immunization Clinics intervention was designed to improve adolescent immunization rates by partnering with local schools to provide convenient access to vaccinations. Initiated as a pilot project in Shasta County, this program conducted vaccine clinics at schools to increase vaccination rates among adolescents. Partnership co-presented this topic at the 2023 DHCS Quality Conference with a school nurse. The success of the pilot led to the expansion of additional clinics in the 2023–24 school year. By bringing immunization services directly to the school environment, the program aimed to address barriers such as lack of access to

2022–23 External Quality Review Recommendations Directed to Partnership	Actions Taken by Partnership to Address the External Quality Review Recommendations
	health care facilities, scheduling difficulties, and transportation issues. ♦ To address low rates of childhood and adolescent immunizations, new provider incentives were introduced for the early administration of HPV and influenza vaccines. These incentives included a $50 reward for each assigned member who completed the first dose of HPV between their ninth and 12th birthdays, and a similar reward for members completing their initial influenza two-dose series by 15 months of age. These measures were incorporated into the PCP Quality Incentive Program for 2024. ♦ Partnership launched a mobile mammography program in 2023, with the goal of sponsoring events hosted by providers located in imaging center deserts, in locations where local imaging centers continue to have significant access issues, and in counties with *Breast Cancer Screening—Total* measure rates below the NCQA 50th percentile benchmark. Partnership funds the mobile events and provides extensive technical assistance to providers who host events for their patient populations. In measurement year 2023, both Northeast and Northwest regions' *Breast Cancer Screening—Total* measure rates increased more than 4 percentage points from the previous year, which is significant progress toward the 50th percentile. Partnership is continuing to partner with the vendor to bring access to imaging center deserts in 2023–24. ♦ In Solano County, where a provider shortage significantly reduced access to obstetrical care and affected Southeast Region rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure, a collaborative workgroup of all prenatal care providers was established. This group identified and addressed operational and communication

2022–23 External Quality Review Recommendations Directed to Partnership	Actions Taken by Partnership to Address the External Quality Review Recommendations
	barriers, ultimately improving care systems and reducing wait times for new patient appointments from six weeks to one week at most practices. Partnership is using these lessons to address similar barriers if present in other locations. Partnership has developed a two-pronged approach to work with its provider network to systematically improve quality measure rates plan-wide: ♦ Enhanced Provider Engagement: Partnership has identified providers earning less than 25 percent of their Quality Incentive Program points and has engaged in deliberate discussions to develop strategies to improve quality rates. This strategy requires ongoing collaboration with Partnership's performance improvement coaches throughout the measurement year, completion of an organizational self-assessment, as well as Partnership's leadership presenting its quality rates to the provider organization board or stakeholders. ♦ Modified Quality Incentive Program: Providers placed in the Enhanced Provider Engagement program are placed on a Quality Incentive Program with four core measures. The four measures included are *Breast Cancer Screening—Total*, *Cervical Cancer Screening*, *Child and Adolescent Well-Care Visits—Total*, and *Well-Child Visits in the First 30 Months of Life*. Placement on the Modified Quality Incentive Program continues until practices earn over 50 percent of their points on the reduced measure set. In measurement year 2023, providers placed on the Modified Quality Incentive Program earned an average of 11.5 percent more points in their Quality Incentive

2022–23 External Quality Review Recommendations Directed to Partnership	Actions Taken by Partnership to Address the External Quality Review Recommendations
	Program scores than in measurement year 2022. Both strategies have proven successful in creating focus and improvement in quality scores, and as such have been continued and expanded to more low-performing providers in 2024. Partnership put substantial effort into outreach and communication efforts for the Equity Practice Transformation funding opportunity, which received applications in fall 2023 and began in 2024. Within Partnership's provider network, 56 providers applied to participate in the Equity Practice Transformation program, and 27 providers were accepted into the program by DHCS. Partnership believes that the Equity Practice Transformation program, with its emphasis on foundation components of high-functioning PCP practices, is an especially important opportunity for participating practices to build their capacity to maximize their limited resources and improve their performance on MCAS measures. Partnership will continue to work with provider practices as DHCS updates the program based on budgetary changes.

Assessment of Partnership's Self-Reported Actions

HSAG reviewed Partnership's self-reported actions in Table C.20 and determined that Partnership adequately addressed the 2022–23 EQR recommendations.

Partnership indicated that all findings from DHCS' most recent compliance review scoring process were from DHCS' Medical Audit of the MCP. Partnership indicated that the MCP worked with DHCS to implement corrective actions to address the findings related to blood lead screening, IHAs, and oversight of Medi-Cal enrollment for transportation providers. Based on Partnership's corrective actions, DHCS closed Partnership's CAP.

Partnership summarized region-specific factors that contributed to the MCP's performance below the MPLs in measurement year 2022, citing provider shortages as a major challenge. To address provider shortages, Partnership launched a robust provider recruitment and retention program throughout its provider network that included offering signing bonuses.

Partnership indicated that it facilitates internal multidisciplinary workgroups dedicated to improving performance measure rates. Interventions developed by these workgroups include:

- Provided point-of-care devices to clinics to improve blood lead screening rates.
- Partnered with schools to provide convenient access to vaccinations.
- Offered new provider incentives for HPV and influenza vaccines.
- Launched a mobile mammography program.
- Established a prenatal care provider collaborative workgroup in Solano County to improve member access to obstetrical care in this county.

Partnership also reported implementing the following planwide interventions to improve performance on measures:

- Enhanced engagement with low-performing providers to develop strategies to improve measure rates.
- Modified Partnership's Quality Incentive Program to include the following four core measures:
  - *Breast Cancer Screening—Total*
  - *Cervical Cancer Screening*
  - *Child and Adolescent Well-Care Visits—Total*
  - *Well-Child Visits in the First 30 Months of Life*

The interventions Partnership implemented may have contributed to the rates for the following measures moving from below the MPLs in measurement year 2022 to above the MPLs in measurement year 2023:

- *Cervical Cancer Screening* for the Northwest Region
- *Child and Adolescent Well-Care Visits—Total* for the Southwest Region
- *Lead Screening in Children* for the Northwest Region
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for the Southeast Region
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* for the Southwest Region

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Partnership

Based on the overall assessment of Partnership's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Partnership's activities and services affect the quality, timeliness, and accessibility of care

delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to Partnership's 2023 and 2024 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of each PIP.
- For all measures except the LTC measures, the HSAG auditor determined that Partnership followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- Partnership performed above the HPLs for the following measures in measurement year 2023:
  - *Immunizations for Adolescents—Combination 2* for the Southeast Region
  - *Prenatal and Postpartum Care—Postpartum Care* for the Southeast and Southwest regions
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for the Southwest Region
- Based on its performance measure results across all reporting units, Partnership performed better in the Southwest and Southeast regions, where the MCP met or exceeded the MPLs for 12 and 11 performance measure rates, respectively.
- Partnership reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for Partnership show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, HSAG noted that Partnership had a:
  - Well-defined process in place for contracting with providers and entering data into SugarCRM.
  - Comprehensive vetting process for maintaining accurate provider information.

Opportunities for Improvement

- Partnership was unable to include dual eligible members in the MCP's LTC measure calculations.
- Across all reporting units in measurement year 2023, Partnership performed below the MPLs for 40 of the 72 measure rates that HSAG compared to benchmarks (56 percent).
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for Partnership:
  - Grievance and Appeal Systems—§438.228
  - Quality Assessment and Performance Improvement Program—§438.330

- During the NAV audit process, although Partnership demonstrated that it was conducting internal monitoring and oversight, Partnership indicated challenges with internal monitoring of provider ratios due to uncertainty in guidelines of expected methodologies to be used and potential differences relative to the methodologies that DHCS was applying in its calculations. In addition, Partnership mentioned using a methodology, 100 Points of Light, in calculating member addresses as part of internal monitoring for time/distance, which was not a methodology referenced in the APL 23-001.

2023–24 External Quality Review Recommendations

- Implement the steps needed to ensure Partnership is able to include dual eligible members in the MCP's measurement year 2024 LTC performance measure rates.
- Based on the audited performance measure rates changing from reporting unit level in measurement year 2023 to plan level in measurement year 2024, and the counties in which the MCP operates changing as of January 1, 2024, Partnership should assess measurement year 2023 performance to determine priority areas for improvement. The MCP should continue implementing interventions that have resulted in positive outcomes and identify new quality improvement strategies as applicable to address factors affecting performance.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure Partnership meets all CFR standard requirements moving forward:
  - Grievance and Appeal Systems—§438.228
  - Quality Assessment and Performance Improvement Program—§438.330
- Evaluate the DHCS ANC APL and outreach to DHCS to ensure Partnership has a clear understanding of DHCS' expectations for calculating network adequacy indicators.

Partnership's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of Partnership as well as the plan's progress with addressing these recommendations.

San Francisco Health Plan

Follow-Up on Prior Year Recommendations

Table C.21 provides the 2022–23 EQR recommendations directed to SFHP, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.21 to preserve the accuracy of SFHP's self-reported actions.

Table C.21—SFHP's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to SFHP	Actions Taken by SFHP to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure SFHP meets all CFR standard requirements moving forward.	SFHP developed a CAP and has worked with DHCS' Medical Audit CAP Compliance Unit to provide evidence of correction so that DHCS can close the CAP for any open findings from both the 2022 and 2023 Medical Audits. SFHP submitted the CAP to DHCS for the 2022 Medical Audit on September 19, 2022. On October 18, 2022, DHCS provided SFHP with a closure letter for the 2022 CAP and noted five findings that would carry over to the 2023 CAP. SFHP submitted additional documentation to DHCS on October 25, 2022; November 25, 2022; December 23, 2022; January 26, 2023; and February 16, 2023, to help remediate these open deficiencies. DHCS conducted the 2023 Medical Audit at SFHP from February 25, 2023, through March 1, 2023. SFHP submitted the CAP for the 2023 Medical Audit on August 18, 2023. SFHP submitted additional documentation on September 15, 2023; October 15, 2023; November 15, 2023; January 26, 2024; February 23, 2024; March 25, 2024; and May 13, 2024. Of the 17 findings, only two remain open as "partially accepted" by DHCS while SFHP awaits review and final closure from DHCS.

2022–23 External Quality Review Recommendations Directed to SFHP	Actions Taken by SFHP to Address the External Quality Review Recommendations
	Please note that DHCS only identified findings in the Medical Audit portion of the CFR compliance review.
2. Assess the factors that contributed to SFHP performing below the MPLs in measurement year 2022 for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measures and implement quality improvement strategies that target the identified factors. a. For the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure, assess whether the MCP's provider education and member outreach strategies need to be revised to increase the percentage of members turning 15 months old who complete six or more well-child visits.	Factors contributing to SFHP performing below the MPL for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure: ♦ Due to specialty mental health being carved out from the MCP, SFHP does not receive data on care that members may receive from their specialty mental health providers through San Francisco Behavioral Health Services. This gap in data may contribute to an artificially lower rate for follow-up. The MCP has attempted to obtain these data from San Francisco Behavioral Health Services and the California Department of Managed Health Care, but those entities have declined to share such data. ♦ There is a lack of care coordination support at emergency departments to coordinate post-discharge follow-up. ♦ Challenges in obtaining timely access to provider appointments result in members being unable to access care at the right place and right time. ♦ Members may not be interested in receiving follow-up care. ♦ Members navigating mental illness may have challenges with motivation; avolition can be a symptom of mental illness that can make it difficult to start or finish tasks such as taking steps to schedule and complete follow-up care. Factors contributing to SFHP's performance below the MPL for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the*

2022–23 External Quality Review Recommendations Directed to SFHP	Actions Taken by SFHP to Address the External Quality Review Recommendations
	First 15 Months—Six or More Well-Child Visits measure: ♦ SFHP worked with its largest network provider, San Francisco Health Network, and identified a pattern in the data: newborn members' first well-child visit was often submitted as a claim or encounter associated with the birthing parent instead of the newborn, resulting in that first visit not being correctly attributed to the child. SFHP has since corrected this data issue. ♦ Challenges in obtaining timely access to provider appointments result in members being unable to access care at the right place and right time. ♦ Social determinants of health such as transportation to appointments impact member access to care; SFHP providers have described that members missing appointments and needing to reschedule due to social determinant circumstances such as transportation or missing work have resulted in rescheduled appointments that are outside of the 15-month eligibility period. ♦ Gaps in Medi-Cal coverage are more common for members while seeking infant care: 94.8 percent for Medi-Cal members versus 30.0 percent for San Francisco County overall. These gaps may result in delays in scheduling and attending appointments. SFHP's assessment of provider education and member outreach strategies for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure determined that the MCP needed to revise the provider and member education regarding this measure. Following are the major efforts SFHP has undertaken to address outreach to members and providers:

2022–23 External Quality Review Recommendations Directed to SFHP	Actions Taken by SFHP to Address the External Quality Review Recommendations
	• Provider Collaboration Meetings: Since June 2023, SFHP has met monthly with quality staff members from network provider groups to discuss and align quality and health equity priorities, identify gaps, and work collaboratively to close gaps. These meetings have resulted in increased provider education and member outreach. ♦ Sharing Member Data with Providers: The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure is included in SFHP's P4P program in which providers must meet targets by the end of the calendar year to earn incentive payments. To assist providers in achieving their targets, SFHP staff members share monthly gaps-in-care/noncompliant lists that include members eligible for the measure who have not completed the required six visits. Included in these data are the number of visits that have been completed so that providers can choose to target members who are closer or farther from reaching the six visits target. ♦ Gap Analysis: From August 2023 to January 2024, SFHP staff members completed a *Maternal Child Health Gap Analysis Report* to assess disparities and gaps in several priority quality measures including the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure. Included in this *Maternal Child Health Gap Analysis Report* was a cause and effect analysis (fishbone diagram), identifying areas that are associated with or considered a cause for child health disparities and challenges in meeting the MPL for well-child visits. Included in this fishbone diagram were detailed analyses of socioeconomic factors, issues with lack of member autonomy, challenges with member mental health, aspects of distrust

2022–23 External Quality Review Recommendations Directed to SFHP	Actions Taken by SFHP to Address the External Quality Review Recommendations
	of the medical system, lack of knowledge about health benefits, and the impacts of access to perinatal care. This report was created based on SFHP staff members' experiences working with members, reviewing literature, and reviewing available CDPH data. ♦ Member Incentive for Timeliness: SFHP incentivizes members to complete six well-child visits in the first 15 months of life. MCP staff members discovered that before 2023, eligible members were informed of this incentive three or four months after the child was born and once more several months before the 15-month cutoff. In 2023 and 2024, SFHP staff members changed the initial incentive outreach to start at one month and occur more frequently over the 15-month eligibility period. This member outreach will result in members receiving more frequent education about well-child visits. ♦ Direct Member Incentive Pilot: In 2022, SFHP improved the member incentive process by removing the requirement for members to obtain a provider's signature to obtain a member incentive, thus reducing barriers for the members to receive the member incentive. In 2024, one of SFHP's provider groups, San Francisco Health Network, informed the MCP's staff members that this removal may have had an unintended effect of disconnecting the care the member receives to the member incentive—in other words, reduced the feedback loop. Given the complexity of the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure requirements and the frequency of appointments required to be compliant for the measure, the MCP and San Francisco Health Network will complete a pilot spanning from September 1, 2024, to December 31, 2024, wherein San Francisco Health Network's

2022–23 External Quality Review Recommendations Directed to SFHP	Actions Taken by SFHP to Address the External Quality Review Recommendations
	clinic, Children's Health Center, will provide a gift card directly to families after the child's sixth visit. This initiative engages providers aiming to reward members for participating in their care, establishes a robust positive feedback loop between the clinic and SFHP members, and has the potential to improve the rates for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure for a delegate with a high volume of pediatric members. To address SFHP's performance below the MPL for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure, the MCP determined to include the following two activities in its Quality Improvement Health Equity Transformation Program workplan: ♦ Emergency department navigators provide motivational interviewing and referral to members' enhanced care management provider or PCP for a follow-up visit. ♦ Incentivize providers by including this measure in SFHP's primary care P4P program. Additional strategies SFHP implemented to improve performance on the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure included: ♦ Sent to providers weekly reports of member emergency department visits for mental health diagnoses. ♦ Improved data exchange between SFHP and its providers to ensure that follow-up visits that occur are correctly counted.

Assessment of SFHP's Self-Reported Actions

HSAG reviewed SFHP's self-reported actions in Table C.21 and determined that SFHP adequately addressed the 2022–23 EQR recommendations.

SFHP indicated that all findings from DHCS' most recent compliance review scoring process were from DHCS' Medical Audit of the MCP. SFHP provided details regarding the MCP's submission of corrective actions to DHCS and indicated that DHCS has closed all but two of the 17 findings from the compliance review.

SFHP described in detail the factors contributing to the MCP performing below the MPL for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure in measurement year 2022. SFHP also reported that its assessment of the provider education and member outreach strategies it was implementing resulted in the MCP making revisions, including:

- Facilitated monthly provider collaboration meetings to discuss strategies for closing care gaps.
- Shared member data with providers so the providers could target outreach to members who have not completed the recommended number of well-child visits.
- Revised the MCP's member outreach regarding the importance of completing all recommended well-child visits and informing the members about the well-child visit incentive to occur one month sooner and more frequently.
- Improved SFHP's member incentive process by removing the requirement for members to obtain a providers' signature to receive the incentive.

To improve SFHP's performance for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure, SFHP described the following strategies:

- Emergency department navigators provided motivational interviewing and referral to members' enhanced care management provider or PCP for a follow-up visit.
- Incentivized providers by including this measure in SFHP's primary care P4P program.
- Sent to providers weekly reports of member emergency department visits for mental health diagnoses.
- Improved data exchange between SFHP and its providers to ensure that follow-up visits that occur are correctly counted.

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for SFHP

Based on the overall assessment of SFHP's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of SFHP's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned a *High Confidence* level to SFHP's 2023 and 2024 clinical PIP submissions, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of its clinical PIP.
- The HSAG auditor determined that SFHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- SFHP performed above the HPLs for the following measures in measurement year 2023:
  - *Childhood Immunization Status—Combination 10*
  - *Chlamydia Screening in Women—Total*
  - *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - *Immunizations for Adolescents—Combination 2*
  - *Prenatal and Postpartum Care—Postpartum Care*
- DHCS' 2024 compliance review scores for SFHP show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, HSAG noted that SFHP had a well-defined process in place for collecting and maintaining both provider and member data in its source systems. Additionally, HSAG identified no specific opportunities for improvement related to the data collection and management processes SFHP had in place to inform network adequacy standard and indicator calculations.

Opportunities for Improvement

- HSAG's 2024 PIP validation determined that SFHP failed to include all required details of its PIP processes for its nonclinical PIP.
- SFHP performed below the MPLs in measurement year 2023 for the following four of 18 measure rates that HSAG compared to benchmarks (22 percent):
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
  - *Topical Fluoride for Children—Dental or Oral Health Services—Total*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- SFHP has remaining findings to resolve from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for SFHP:
  - Availability of Services—§438.206
  - Coordination and Continuity of Care—§438.208
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Quality Assessment and Performance Improvement Program—§438.330

2023–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure SFHP includes all required information in the MCP's 2025 annual nonclinical PIP submission.
- For measures for which SFHP performed below the MPLs in measurement year 2023, identify the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, SFHP should determine whether the member- and provider-focused interventions described in Table C.21 need to be revised or abandoned based on intervention evaluation results.
- Work with DHCS to fully resolve the findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure SFHP meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206

- Coordination and Continuity of Care—§438.208
- Grievance and Appeal Systems—§438.228
- Subcontractual Relationships and Delegation—§438.230
- Quality Assessment and Performance Improvement Program—§438.330

SFHP's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of SFHP as well as the plan's progress with addressing these recommendations.

Santa Clara Family Health Plan

Follow-Up on Prior Year Recommendations

Table C.22 provides the 2022–23 EQR recommendations directed to SCFHP, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.22 to preserve the accuracy of SCFHP's self-reported actions.

Table C.22—SCFHP's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to SCFHP	Actions Taken by SCFHP to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure SCFHP meets all CFR standard requirements moving forward.	DHCS has accepted SCFHP's CAPs, and DHCS closed the CAPs related to the following identified findings: **5.1.1 Evaluation of Potential Quality Issues (PQIs)** The following documentation supports SCFHP's efforts to correct this finding: Staffing ♦ The MCP provided confirmation that it hired a temporary quality improvement registered nurse (RN) in January 2024. SCFHP continues to recruit for a full-time nurse as of March 2024. Policies and Procedures ♦ Updated Policy QI.05.01 (Potential Quality of Care Issues) to strengthen the clinical review process for PQIs. If medical records are not received two weeks before the deadline, an escalation email is resent to the provider network operations and executive teams for assistance. Monitoring ♦ Review of the August 2023 PQI dashboard demonstrated that the MCP has a process in place to monitor PQIs for timely evaluation.

2022–23 External Quality Review Recommendations Directed to SCFHP	Actions Taken by SCFHP to Address the External Quality Review Recommendations
	♦ The quality and safety manager will review and monitor weekly the status of cases being closed within 90 days. ♦ On October 13, 2023, SCFHP implemented weekly meetings with the grievances and appeals clinical specialist RN/temporary RN and quality improvement coordinators to ensure that all needed medical records are available so that PQI cases can be closed in a timely manner. ♦ SCFHP's tracking tools demonstrate that the MCP is tracking individual PQI cases. **5.1.2 Reporting of PQI to Governing Board** The following documentation supports SCFHP's efforts to correct this finding: Policies and Procedures ♦ Policy and Procedure QI.05.01 v12 (Potential Quality of Care Issues), which SCFHP revised on July 11, 2024, demonstrates that the MCP made policy and procedure revisions to include that Quality Improvement Committee (QIC) meeting minutes will document discussion and review of quality improvement activities. In addition, any actions and/or improvements taken by the QIC will be provided to the Governing Board. Implementation ♦ Governing Board meeting minutes demonstrate evidence of the Board reviewing the QIC meeting minutes and confirming the QIC discussed PQIs. ■ The PQI discussions included that there is a backlog due to limited resources and that SCFHP determined to recruit for open RN and temporary RN positions.

2022–23 External Quality Review Recommendations Directed to SCFHP	Actions Taken by SCFHP to Address the External Quality Review Recommendations
	▪ The Board noted that 83.3 percent of PQIs, due from April to June 2023, closed within the 90-day required time frame. ▪ The Board confirmed that the QIC discussed the 2023 DHCS audit findings and actions taken for the three findings. ▪ The Board reviewed the 2023 Q1 and Q2 PQI Tracking/Trending Report, which indicated that there were 70 closed PQIs. Insight was provided on the top three PQI case categories: Diagnosis Issues, Adverse Occurrence, and Treatment Issues. A CAP was issued for providers that had three or more CAPs in Q1 and Q2 2023; the transportation vendor had five CAPs, and a skilled nursing facility had three CAPs. Each provider had one downgrade of PQI after its CAP response was received. In addition, the MCP informed the QIC about unresolved PQIs resulting from staffing challenges. SCFHP set the goal to clear the backlog PQIs by the end of December 2023. SCFHP hired a temporary medical director to help review the PQIs to help meet this goal. ♦ The Medi-Cal 2023 Quality Improvement Work Plan demonstrates the current progress and action items for PQIs. ▪ SCFHP's response to DHCS on March 15, 2023, indicated that the responsibility to monitor PQI falls on the QIC (now known as QIHEC), which is a committee of the Governing Board. The MCP noted that any reports, actions taken, and improvements will be discussed within QIC/QIHEC. The Governing Board receives reports and minutes from the QIC/QIHEC, which is documented within the Board meeting minutes; however, a discussion may not occur if members

2022–23 External Quality Review Recommendations Directed to SCFHP	Actions Taken by SCFHP to Address the External Quality Review Recommendations
	accept the written QIC/QIHEC minutes as-is. Monitoring and Oversight ♦ The monitoring tool verifies if the QIC is reporting actions taken and improvements made for PQI processing issues to the Governing Board. The compliance officer will monitor this tool and will consult with the director. In addition, the QIC will ensure compliance. **5.1.3 Provider Involvement of PQI Cases** The following documentation supports the MCP's efforts to correct this finding: Policies and Procedures ♦ The Desktop Procedure—Medical Record Requests—demonstrates the actions required to escalate requests for medical records. ♦ Revised Policy and Procedure QI.05.01 v12 on July 11, 2024, to include two additional escalation processes in order to receive medical records on a timely basis from providers, hospitals, and facilities. SCFHP indicated to DHCS that since the MCP implemented its escalation process, there have been no issues with non-responsiveness. Monitoring and Oversight ♦ SCFHP's escalation tracker serves as documentation that the MCP is monitoring its providers for medical records not received in a timely manner. ♦ Quality Improvement PQI Tracking and Trending Report (January–June 2023) demonstrates that the MCP presented a

2022–23 External Quality Review Recommendations Directed to SCFHP	Actions Taken by SCFHP to Address the External Quality Review Recommendations
	Microsoft PowerPoint presentation to its QIC. SCFHP processes this report every six months. ♦ Quality Improvement PQI Tracking and Trending Report (July–December 2023) demonstrates that the MCP presented a Microsoft PowerPoint presentation to its QIHEC Committee. SCFHP processes this report every six months. ♦ Quality Improvement Workplan Medi-Cal 2023 Q3 Update included identifying PQIs. Training ♦ Various Joint Operations Committee meeting agendas demonstrate that SCFHP shared the updated escalation process with delegated entities.
2. Assess the factors that contributed to SCFHP performing below the MPL in measurement year 2022 for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure and implement quality improvement strategies that target the identified factors. As part of its assessment, the MCP should determine whether its member- and provider-focused interventions need to be revised to increase the percentage of members turning 15 months old who complete six or more well-child visits.	The measurement year 2022 rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure improved over measurement year 2021; however, the rate remained below the MPL due to members missing visits, visits being completed outside the compliance requirement due to scheduling availability, and SCFHP's plan partner not requiring a nine-month visit. Interventions for measurement year 2023 included: ♦ Implementing focused member outreach to ensure that members are attending their well-child visits and helping members attend these visits when needed. ♦ Implementing and enhancing SCFHP's baby to mom mapping to capture the newborn visits that were recorded under the mother's name.

2022–23 External Quality Review Recommendations Directed to SCFHP	Actions Taken by SCFHP to Address the External Quality Review Recommendations
	♦ Conducting provider education and supporting workflow improvement and practice transformation.

Assessment of SCFHP's Self-Reported Actions

HSAG reviewed SCFHP's self-reported actions in Table C.22 and determined that SCFHP adequately addressed the 2022–23 EQR recommendations. SCFHP indicated that it submitted to DHCS corrective actions the MCP took to resolve the findings from DHCS' compliance review related to PQIs. In response to SCFHP's corrective actions, DHCS closed the CAP.

To improve SCFHP's performance on the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure, the MCP reported implementing member- and provider-focused interventions, including:

- Implemented focused member outreach.
- Enhanced data capture methods.
- Conducted provider education.
- Supported provider workflow improvement and practice transformation.

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for SCFHP

Based on the overall assessment of SCFHP's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of SCFHP's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to SCFHP's 2023 clinical and nonclinical PIP submissions, reflecting that the MCP built a robust foundation in the Design stage of each PIP.
- HSAG assigned a *High Confidence* level to SCFHP's 2024 nonclinical PIP submission, reflecting that the MCP built a robust foundation in both the Design and Implementation stages of its nonclinical PIP.

- The HSAG auditor determined that SCFHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- SCFHP performed above the HPLs for the following measures in measurement year 2023:
  - *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - *Immunizations for Adolescents—Combination 2*
- SCFHP reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*. Resolving these findings may result in improved quality of care for the MCP's members.
- DHCS' 2024 compliance review scores for SCFHP show that the MCP was fully compliant with most CFR standards.
- During the NAV audit process, HSAG identified no specific opportunities for improvement related to the data collection and management processes SCFHP had in place to inform network adequacy standard and indicator calculations. Additionally, HSAG noted the following:
  - At least annually, SCFHP conducted an analysis to identify gaps within Santa Clara County by demographic area and provider type. When gaps were identified, SCFHP conducted an analysis to identify potential providers who are not currently in network and conducted outreach to evaluate interest in becoming a contracted provider.
  - SCFHP required delegates to report their contracting efforts status to close gaps for the identified potential providers.

Opportunities for Improvement

- HSAG's 2024 PIP validation determined that SCFHP failed to include all required details of its PIP processes for its clinical PIP.
- SCFHP performed below the MPLs in measurement year 2023 for the following four of 18 measure rates that HSAG compared to benchmarks (22 percent):
  - *Controlling High Blood Pressure—Total*
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
  - *Topical Fluoride for Children—Dental or Oral Health Services—Total*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for SCFHP:
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228

- Subcontractual Relationships and Delegation—§438.230
- Quality Assessment and Performance Improvement Program—§438.330

2023–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure SCFHP includes all required information in the MCP's 2025 annual clinical PIP submission.
- For measures for which SCFHP performed below the MPLs in measurement year 2023, identify the factors that affected the MCP's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, SCFHP should determine whether the member- and provider-focused interventions described in Table C.22 need to be revised or abandoned based on intervention evaluation results.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure SCFHP meets all CFR standard requirements moving forward:
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Quality Assessment and Performance Improvement Program—§438.330

SCFHP's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of SCFHP as well as the plan's progress with addressing these recommendations.

SCAN Health Plan

Follow-Up on Prior Year Recommendations

Table C.23 provides the 2022–23 EQR recommendations directed to SCAN, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table C.23 to preserve the accuracy of SCAN's self-reported actions.

Table C.23—SCAN's Self-Reported Follow-Up on the 2022–23 External Quality Review Recommendations

2022–23 External Quality Review Recommendations Directed to SCAN	Actions Taken by SCAN to Address the External Quality Review Recommendations
1. Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure SCAN meets all CFR standard requirements moving forward.	**1.3.1 Appeal Reviews of Medi-Cal Benefits:** SCAN did not ensure its appeal process for dual eligible members included a review of criteria for covered services under the Medi-Cal program. **Action Taken by SCAN:** The grievance and appeals team reviewed and updated policies and implemented a weekly report to identify and review all Dual Special Needs Plan (D-SNP) upheld appeals to confirm that the decision was made based on both Medicare and Medi-Cal benefit guidelines. **4.1.1 Timely Grievance Acknowledgment:** SCAN did not send acknowledgement of grievance receipt notices to members within five calendar days. **Action Taken by SCAN:** The grievance and appeals team hired additional staff members and implemented a biweekly report to identify all D-SNP cases for which an acknowledgement letter was not sent, as well as the language of choice by the member.

2022–23 External Quality Review Recommendations Directed to SCAN	Actions Taken by SCAN to Address the External Quality Review Recommendations
	4.2.1 Language Assistance Taglines: SCAN's language assistance taglines excluded two non-English languages: Mien and Ukrainian. **Action Taken by SCAN**: SCAN's health care services and medical management teams have revised the language assistance tagline template to include all languages in accordance with APL 21-004, "Access and Availability to Linguistic Services and Discrimination Grievance Process"; educated delegates on the updated document for member notifications; updated the delegation oversight audit tool; and updated the multi-language insert in the 2024 Member Handbook. During the 2022–23 review period, DHCS only identified findings in the DHCS Medical Audit portion of the compliance audit review, and DHCS closed the Medical Audit CAP on January 29, 2024.

Assessment of SCAN's Self-Reported Actions

HSAG reviewed SCAN's self-reported actions in Table C.23 and determined that SCAN adequately addressed the 2022–23 EQR recommendations. SCAN indicated that all findings from DHCS' most recent compliance review scoring process were from DHCS' Medical Audit of the PSP. SCAN described each finding and the steps the PSP took to fully resolve all findings, including:

- Updated SCAN's grievances and appeals policies.
- Implemented a process to review all upheld appeals.
- Hired additional staff members and implemented a process to ensure SCAN sends grievance acknowledgement letters to members in the required time frame.
- Revised SCAN's language assistance taglines to include all required languages.

Based on SCAN's corrective actions, DHCS closed the CAP on January 29, 2024.

2023–24 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for SCAN

Based on the overall assessment of SCAN's delivery of quality, timely, and accessible care through the 2023–24 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of SCAN's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

Strengths

- HSAG assigned *High Confidence* levels to SCAN's 2023 clinical and nonclinical PIP submissions, reflecting that the PSP built a robust foundation in the Design stage of each PIP.
- The HSAG auditor determined that SCAN followed the appropriate specifications to produce valid performance measure rates for measurement year 2023 and identified no issues of concern.
- SCAN performed above the HPLs for the following measures in measurement year 2023:
  - *Breast Cancer Screening—Total*
  - *Controlling High Blood Pressure—Total*
  - *Hemoglobin A1c Control (HbA1c) for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
- SCAN reported fully addressing all findings from DHCS' CFR standard compliance review, which HSAG reported in the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*.
- DHCS' 2024 compliance review scores for SCAN show that the PSP was fully compliant with most CFR standards.
- During the NAV audit process, HSAG noted that SCAN had robust processes in place to ensure ongoing accuracy and completeness across delegated provider groups by outreaching every 90 days to gather any changes.

Opportunities for Improvement

- HSAG's 2024 PIP validation determined that SCAN failed to include all required details of its PIP processes for both clinical and nonclinical PIPs.
- SCAN performed below the MPL in measurement year 2023 for the *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* measure.
- DHCS identified findings within the following CFR standards during the DHCS 2024 compliance review scoring process for SCAN:

  - Availability of Services—§438.206
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Quality Assessment and Performance Improvement Program—§438.330
- During the NAV audit process, although SCAN demonstrated that it was conducting monitoring activities for time/distance according to CMS requirements, HSAG observed that SCAN was not conducting ongoing monitoring activities relative to DHCS requirements for the network adequacy standards in scope of review.

2023–24 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions to ensure SCAN includes all required information in the MCP's 2025 annual clinical and nonclinical PIP submissions.
- Identify the factors that contributed to the PSP's performance below the MPL for the *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* measure for measurement year 2023 and implement quality improvement strategies that target the identified factors.
- Work with DHCS to resolve the identified findings from DHCS' 2024 compliance review scoring process related to the following CFR standards to ensure SCAN meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228
  - Quality Assessment and Performance Improvement Program—§438.330
- Work with DHCS to ensure clear understanding and expectations of monitoring activities and methodologies to ensure alignment with DHCS' requirements.

SCAN's responses to the EQR recommendations should reflect strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.

In the next annual review, HSAG will evaluate the continued successes of SCAN as well as the plan's progress with addressing these recommendations.