Volume 2 of 3

Medi-Cal Managed Care External Quality Review Technical Report

July 1, 2018–June 30, 2019

Plan-Specific Evaluation Reports
Appendices A through FF

Managed Care Quality and Monitoring Division
California Department of Health Care Services

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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS California Department of HealthCareServices

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix A:
Performance Evaluation Report
Access Dental Plan
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS' contracted Medi-Cal dental managed care (DMC) plan, Access Dental Plan ("Access Dental" or "the DMC plan"). The purpose of this appendix is to provide DMC-specific results of each activity and an assessment of the DMC plan's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to dental care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as "beneficiaries" in this report). The review period for this DMC plan-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in Access Dental's 2019–20 MCP-specific evaluation report. This DMC plan-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all managed care health plan (MCP), population-specific health plan (PSP), specialty health plan (SHP), and DMC plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCPs, PSPs, SHPs, and DMC plans are providing to beneficiaries.

Medi-Cal Dental Managed Care Plan Overview

Access Dental operates in Los Angeles County as a Prepaid Health Plan (PHP) and in Sacramento County under a Geographic Managed Care (GMC) model. In Los Angeles County beneficiaries have the option of enrolling in a DMC plan or accessing dental benefits through the dental fee-for-service (FFS) delivery system, whereas in Sacramento County DMC enrollment is mandatory.

Access Dental became operational as a DMC plan in Los Angeles County effective July 1, 2013, and in Sacramento County effective January 1, 2013. As of June 2019, Access Dental had 145,701 beneficiaries in Los Angeles County and 126,781 in Sacramento County—for a total of 272,482 beneficiaries.[1] This represents 38 percent of the DMC beneficiaries enrolled in Los Angeles County and 30 percent of DMC beneficiaries enrolled in Sacramento County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Dental Managed Care Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Access Dental. The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes results and status of the most recent Department of Managed Health Care (DMHC) Routine Survey of Access Dental. DMHC conducted the initial on-site survey from March 29, 2016, through March 31, 2016, and subsequent on-site follow-up survey from January 23, 2018, through January 25, 2018, to assess the status of any findings that remained uncorrected at the time DMHC issued the final report. While DMHC conducted the surveys outside the review period for this DMC plan-specific evaluation report, HSAG includes the information because these are the most recent surveys conducted by DMHC.

Table 2.1—2016 DMHC Routine Survey of Access Dental

Category Evaluated	Deficiencies/ Findings (Yes/No)	Monitoring Status
Section I: Knox-Keene Survey		
Quality Management	Yes	Corrected.
Grievances and Appeals	Yes	Corrected.
Access and Availability of Services	No	Not applicable.
Utilization Management	Yes	Not corrected. Compliance is being monitored by DMHC.
Language Assistance	Yes	Corrected.
Section II: Medi-Cal Dental Managed Care Survey		
Access and Availability	Yes	Corrected.
Grievance and Appeals Policy and Procedures	Yes	Corrected.
Quality Management	No	Not applicable.
Utilization Management	No	Not applicable.

Strengths—Compliance Reviews

DMHC identified no findings in the Access and Availability of Services Knox-Keene Survey category or the Quality Management and Utilization Management Medi-Cal Dental Managed Care Survey categories evaluated during the March 2016 Routine Survey of Access Dental.

Opportunities for Improvement—Compliance Reviews

Access Dental has no outstanding findings pending with DHCS from the March 2016 DMHC Routine Survey or January 2018 follow-up survey; therefore, HSAG has no recommendations for the DMC plan in the area of compliance reviews.

3. Dental Managed Care Plan Performance Measures

DHCS requires DMC plans to submit quarterly self-reported performance measure rates for each reporting unit (i.e., Los Angeles County and Sacramento County). To provide ongoing, consistent comparison over time, DMC plans use a rolling 12-month methodology to display rates for a full year within each quarterly performance measure rate report.

Reporting year 2019 was the first year that DHCS required DMC plans to submit both reporting units' audited performance measure rates reflecting measurement year (MY) data from the previous calendar year. In April 2019, Access Dental submitted both reporting units' reporting year 2019 performance measure rates reflecting measurement year 2018 data (i.e., January 1, 2018, through December 31, 2018).

Performance Measure Results

Table 3.1 and Table 3.2 present Access Dental's reporting year 2019 audited performance measure rates for each DMC plan reporting unit. To allow HSAG to provide a meaningful display of DMC plan performance, HSAG organized the performance measures according to the health care areas that each measure affects (i.e., Access to Care and Preventive Care).

Note that HSAG could not compare reporting year 2019 DMC plan performance measure rates to historical data or DHCS' encounter data since reporting year 2019 was the first year that DMC plans were required to report audited performance measure rates; therefore, HSAG makes no conclusions or recommendations related to DMC plans' reporting year 2019 performance measure results.

Table 3.1—Reporting Year 2019 (Measurement Year 2018) Dental Managed Care Plan Performance Measure Results
Access Dental—Los Angeles County

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Measure	Reporting Year 2019 Rate
Access to Care	
Annual Dental Visits—0–20 Years	41.7%
Annual Dental Visits—21+ Years	15.9%
Continuity of Care—0–20 Years	61.5%
Continuity of Care—21+ Years	26.2%

Measure	Reporting Year 2019 Rate
Exam/Oral Health Evaluations—0–20 Years	36.0%
Exam/Oral Health Evaluations—21+ Years	11.3%
General Anesthesia—0–20 Years	72.2%
General Anesthesia—21+ Years	70.5%
Overall Utilization of Dental Services–One Year—0–20 Years	41.8%
Overall Utilization of Dental Services–One Year—21+ Years	15.9%
Use of Dental Treatment Services—0–20 Years	17.8%
Use of Dental Treatment Services—21+ Years	10.1%
Usual Source of Care—0–20 Years	32.1%
Usual Source of Care—21+ Years	6.3%
Preventive Care	
Preventive Services to Filling—0–20 Years	84.1%
Preventive Services to Filling—21+ Years	46.4%
Sealants to Restoration Ratio (Surfaces)—6–9 Years	4.81
Sealants to Restoration Ratio (Surfaces)—10–14 Years	3.11
Treatment/Prevention of Caries—0–20 Years	88.9%
Treatment/Prevention of Caries—21+ Years	7.4%
Use of Preventive Services—0–20 Years	36.7%
Use of Preventive Services—21+ Years	7.1%
Use of Sealants—6–9 Years	13.2%
Use of Sealants—10–14 Years	5.8%

Table 3.2—Reporting Year 2019 (Measurement Year 2018) Dental Managed Care Plan Performance Measure Results
Access Dental—Sacramento County

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Measure	Reporting Year 2019 Rate
Access to Care	
Annual Dental Visits—0–20 Years	35.7%
Annual Dental Visits—21+ Years	16.6%
Continuity of Care—0–20 Years	60.6%
Continuity of Care—21+ Years	28.9%
Exam/Oral Health Evaluations—0–20 Years	31.2%
Exam/Oral Health Evaluations—21+ Years	11.0%
General Anesthesia—0–20 Years	71.5%
General Anesthesia—21+ Years	92.7%
Overall Utilization of Dental Services–One Year—0–20 Years	35.9%
Overall Utilization of Dental Services–One Year—21+ Years	16.6%
Use of Dental Treatment Services—0–20 Years	16.3%
Use of Dental Treatment Services—21+ Years	11.8%
Usual Source of Care—0–20 Years	29.5%
Usual Source of Care—21+ Years	8.3%
Preventive Care	
Preventive Services to Filling—0–20 Years	79.5%
Preventive Services to Filling—21+ Years	44.2%
Sealants to Restoration Ratio (Surfaces)—6–9 Years	4.53
Sealants to Restoration Ratio (Surfaces)—10–14 Years	3.01
Treatment/Prevention of Caries—0–20 Years	87.9%
Treatment/Prevention of Caries—21+ Years	8.5%
Use of Preventive Services—0–20 Years	29.7%
Use of Preventive Services—21+ Years	7.2%
Use of Sealants—6–9 Years	10.1%
Use of Sealants—10–14 Years	5.6%

4. Performance Improvement Projects

DHCS requires DMC plans to conduct two quality improvement projects (QIPs) per year. DMC plans must participate in a DHCS-established and facilitated statewide QIP as well as an individual QIP that aligns with a demonstrated area in need of improvement.

Prior to January 2019, DHCS required DMC plans to submit quarterly progress reports for both the statewide and individual QIPs. After discussions with HSAG in January and February of 2019, DHCS modified the requirements for DMC plans. Beginning in February 2019, DHCS required DMC plans to submit two reports annually for the statewide QIP—one intervention progress report to HSAG, and an annual QIP submission to DHCS. Additionally, DHCS required DMC plans to begin conducting their individual QIPs using HSAG's rapid-cycle PIP process. With the transition of DMC plans' individual QIPs to HSAG's rapid-cycle PIP process, HSAG began referring to DMC plans' individual QIPs as individual performance improvement projects (PIPs).

Statewide Quality Improvement Project

DHCS requires DMC plans to conduct statewide QIPs focused on *Preventive Services Utilization*. The goals of the statewide QIP are to increase preventive services among children ages 1 to 20 by 10 percentage points by the end of 2023.

Based on the new reporting requirements, Access Dental participated in HSAG's Statewide QIP Intervention Progress Report Overview webinar in March 2019 to obtain information on the report submission requirements. Access Dental submitted the health plan's first intervention progress report to HSAG in April 2019. The DMC plan reported on identified barriers and interventions conducted as of March 31, 2019. In May 2019, HSAG provided feedback to Access Dental on the intervention progress report, including the following:

- Access Dental provided a key driver diagram, a description of the DMC plan's causal barrier processes and rankings, and intervention implementation and evaluation information.
  - The DMC plan should include drivers, factors, or barriers that drive the PIP outcomes in the key driver diagram.
- The DMC plan should rank the barriers in order of priority and revisit the casual/barrier analysis and priority ranking process at least annually.
- The DMC plan logically linked the interventions to identified barriers and implemented the interventions in a timely manner to directly impact study indicator outcomes.
- The DMC plan provided next steps for the intervention based on intervention evaluation data.

Individual Performance Improvement Project

Based on DHCS' new requirements, the DMC plan began to conduct its individual PIP using HSAG's rapid-cycle PIP process. Access Dental selected annual dental visits for children ages 5 to 18 as its individual PIP topic. In April 2019, Access Dental participated in HSAG's rapid-cycle PIP process overview training session to obtain general background about the key concepts of the rapid-cycle PIP framework as well as submission requirements for modules 1 through 5 and HSAG's PIP validation process.

During the review period for this DMC-specific evaluation report, Access Dental did not progress to submitting any PIP modules for HSAG to validate. Therefore, HSAG includes no validation findings in this report. HSAG will include a summary of the DMC plan's *Increasing an Annual Dental Visit for Children, Ages 5–18* PIP activities and validation findings in Access Dental's 2019–20 DMC-specific evaluation report.

Strengths—Performance Improvement Projects

Access Dental successfully completed the first intervention progress report for the *Preventive Services Utilization* statewide QIP, providing all requested information. The DMC plan also provided all required information to support its *Increasing an Annual Dental Visit for Children, Ages 5–18* individual PIP topic selection.

Opportunities for Improvement—Performance Improvement Projects

Based on Access Dental's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Recommendations

Based on the overall assessment of Access Dental's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the DMC plan.

In the next annual review, HSAG will evaluate continued successes of Access Dental.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix B:
Performance Evaluation Report
Aetna Better Health of California
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Aetna Better Health of California ("Aetna" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in Aetna's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Aetna is a full-scope MCP delivering services to beneficiaries under a Geographic Managed Care (GMC) model. The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

In addition to Aetna, Sacramento County's beneficiaries may select from the following MCPs:

- Anthem Blue Cross Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser NorCal
- Molina Healthcare of California Partner Plan, Inc.

In addition to Aetna, San Diego County's beneficiaries may select from the following MCPs:

- Blue Shield of California Promise Health Plan (known as Care1st Partner Plan prior to January 1, 2019)
- Community Health Group Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser SoCal
- Molina Healthcare of California Partner Plan, Inc.
- UnitedHealthcare Community Plan

Aetna became operational in Sacramento and San Diego counties to provide MCMC services effective January 1, 2018. As of June 2019, Aetna had 7,091 beneficiaries in Sacramento County, and 9,488 in San Diego County—for a total of 16,579 beneficiaries.[1] This represents 2 percent of the beneficiaries enrolled in Sacramento County and 1 percent of the beneficiaries enrolled in San Diego County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent review conducted for Aetna. HSAG's compliance review summary is based on final audit/survey report issued dated on or before the end of the review period for this report (June 30, 2019).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Focused Medical Audit of Aetna. A&I conducted the audit from April 16, 2018, through April 17, 2018, assessing the categories of Utilization Management, Member's Rights, and Quality Management.

Table 2.1—DHCS A&I Focused Medical Audit of Aetna
Audit Review Period: January 1, 2018, through March 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Member's Rights	No	No findings.
Quality Management	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings during the April 2018 Focused Medical Audit of Aetna.

Opportunities for Improvement—Compliance Reviews

Aetna had no findings to address from the April 2018 A&I Focused Medical Audit; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for Aetna Better Health of California* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that Aetna followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.8 for Aetna's performance measure results for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year.

Note the following regarding Table 3.1 through Table 3.8:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results by domain.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For reporting year 2019, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Note the following regarding Aetna's performance measure results:

- Reporting year 2019 is the first year Aetna reported performance measure rates; therefore:
  - DHCS did not hold the MCP accountable to meet minimum performance levels (i.e., DHCS did not require Aetna to submit IPs for measures with rates below the minimum performance levels). As applicable, the performance measure results tables denote instances of rates below the minimum performance levels to help DHCS and Aetna identify potential opportunities for improvement for measures for which DHCS will hold the MCP accountable to meet minimum performance levels for reporting year 2020.
  - HSAG presents no findings and makes no recommendations related to the MCP's reporting year 2019 performance measure results.

Preventive Screening and Children's Health

Table 3.1 and Table 3.2 present the reporting year 2019 results for the performance measures within the Preventive Screening and Children's Health domain.

Table 3.1—Preventive Screening and Children's Health Domain
Reporting Year 2019 Performance Measure Results
Aetna—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

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

Measure	Reporting Year 2019 Rate
Childhood Immunization Status—Combination 3	NA
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**30.56%**
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA
Immunizations for Adolescents—Combination 2	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	NA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**S**

Table 3.2—Preventive Screening and Children's Health Domain
Reporting Year 2019 Performance Measure Results
Aetna—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Measure	Reporting Year 2019 Rate
Childhood Immunization Status—Combination 3	NA
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**35.56%**
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA
Immunizations for Adolescents—Combination 2	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	NA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**S**

Preventive Screening and Women's Health

Table 3.3 and Table 3.4 present the reporting year 2019 results for the performance measures within the Preventive Screening and Women's Health domain.

Table 3.3—Preventive Screening and Women's Health Domain Reporting Year 2019 Performance Measure Results Aetna—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Measure	Reporting Year 2019 Rate
Breast Cancer Screening	NA
Cervical Cancer Screening	**20.48%**
Prenatal and Postpartum Care—Postpartum Care	NA
Prenatal and Postpartum Care—Timeliness of Prenatal Care	NA

Table 3.4—Preventive Screening and Women's Health Domain Reporting Year 2019 Performance Measure Results Aetna—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Measure	Reporting Year 2019 Rate
Breast Cancer Screening	NA
Cervical Cancer Screening	**25.71%**
Prenatal and Postpartum Care—Postpartum Care	**59.38%**
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**S**

Care for Chronic Conditions

Table 3.5 and Table 3.6 present the reporting year 2019 results for the performance measures within the Care for Chronic Conditions domain.

Table 3.5—Care for Chronic Conditions Domain
Reporting Year 2019 Performance Measure Results
Aetna—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

* A lower rate indicates better performance for this measure.

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

Measure	Reporting Year 2019 Rate
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	NA
Asthma Medication Ratio	NA
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	NA
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	NA

Measure	Reporting Year 2019 Rate
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	NA
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**	NA
Comprehensive Diabetes Care—HbA1c Testing	NA
Comprehensive Diabetes Care—Medical Attention for Nephropathy	NA
Controlling High Blood Pressure	NA

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 Performance Measure Results
Aetna—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

* A lower rate indicates better performance for this measure.

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

Measure	Reporting Year 2019 Rate
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	NA
Asthma Medication Ratio	NA
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	NA
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	NA
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	NA
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**	NA
Comprehensive Diabetes Care—HbA1c Testing	NA

Measure	Reporting Year 2019 Rate
Comprehensive Diabetes Care—Medical Attention for Nephropathy	NA
Controlling High Blood Pressure	NA

Appropriate Treatment and Utilization

Table 3.7 and Table 3.8 present the reporting year 2019 results for the performance measures within the Appropriate Treatment and Utilization domain.

Table 3.7—Appropriate Treatment and Utilization Domain Reporting Year 2019 Performance Measure Results Aetna—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

** A lower rate indicates better performance for this measure.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Measure	Reporting Year 2019 Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	49.95
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	3.20
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	NA

Measure	Reporting Year 2019 Rate
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	S
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	NA
*Plan All-Cause Readmissions***	NA
Use of Imaging Studies for Low Back Pain	NA

Table 3.8—Appropriate Treatment and Utilization Domain Reporting Year 2019 Performance Measure Results Aetna—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

** A lower rate indicates better performance for this measure.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Measure	Reporting Year 2019 Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	34.02
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	52.78
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	NA

Measure	Reporting Year 2019 Rate
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	S
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	NA
*Plan All-Cause Readmissions***	NA
Use of Imaging Studies for Low Back Pain	NA

Seniors and Persons with Disabilities Performance Measure Results

Table 3.9 and Table 3.10 present the reporting year 2019 results for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 and Table 3.12 present the reporting year 2019 results for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. Reporting year 2019 is the first year Aetna reported performance measure rates stratified by the SPD and non-SPD populations; therefore, HSAG presents no analyses within Table 3.9 through Table 3.12.

HSAG calculated no SPD/non-SPD rate differences. For the *Ambulatory Care* measures, high and low rates do not necessarily indicate better or worse performance. For all other measures stratified by the SPD and non-SPD populations, HSAG was unable to make a comparison between the reporting year 2019 SPD and non-SPD rates due to all SPD rates having denominators too low for Aetna to report valid rates.

Table 3.9—Reporting Year 2019 SPD Performance Measure Results Aetna—Sacramento County

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

** A lower rate indicates better performance for this measure.

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

Measure	Reporting Year 2019 SPD Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	81.50
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	8.92
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	NA
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA
*Plan All-Cause Readmissions***	NA

Table 3.10—Reporting Year 2019 SPD Performance Measure Results Aetna—San Diego County

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

** A lower rate indicates better performance for this measure.

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

Measure	Reporting Year 2019 SPD Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	93.85
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	70.06
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	NA
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA
*Plan All-Cause Readmissions***	NA

Table 3.11—Reporting Year 2019 Non-SPD Performance Measure Results Aetna—Sacramento County

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

** A lower rate indicates better performance for this measure.

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

Measure	Reporting Year 2019 Non-SPD Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	47.87
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	2.83
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	NA
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	30.56%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA
*Plan All-Cause Readmissions***	NA

Table 3.12—Reporting Year Non-SPD Performance Measure Results Aetna—San Diego County

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

** A lower rate indicates better performance for this measure.

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

Measure	Reporting Year 2019 Non-SPD Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	32.07
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	52.22
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	NA
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	35.56%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA
*Plan All-Cause Readmissions***	NA

Strengths—Performance Measures

The HSAG auditor determined that Aetna followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Opportunities for Improvement—Performance Measures

Reporting year 2019 was the first year Aetna reported performance measure rates; therefore, HSAG identified no opportunities for improvement for the MCP in the area of performance measures.

4. Performance Improvement Projects

DHCS requires that each MCP, PSP, and SHP conduct a minimum of two DHCS-approved performance improvement projects (PIPs) per each Medi-Cal contract held with DHCS. If an MCP, PSP or SHP holds multiple contracts with DHCS and the areas in need of improvement are similar across contracts, DHCS may approve the MCP, PSP, or SHP to conduct the same two PIPs across all contracts (i.e., conduct a total of two PIPs).

Based on Aetna providing services starting January 1, 2018, DHCS waived the requirement for the MCP to conduct PIPs during the review period for this MCP-specific evaluation report. In April 2019, HSAG began to provide trainings and technical assistance to Aetna on the PIP process and requirements so that the MCP will be prepared to conduct PIPs starting in July 2019.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[5] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study to evaluate MCMC encounter data completeness and accuracy via a review of medical records for physician services rendered between January 1, 2017, and December 31, 2017. Aetna began serving Medi-Cal beneficiaries in January 2018; therefore, Aetna was not included in the 2018–19 EDV study.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from Aetna's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of Aetna's self-reported actions.

Table 8.1—Aetna's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Work with DHCS and HSAG to ensure that the MCP fully understands all EQRO activities and DHCS' requirements of the MCP related to each activity.	Aetna's California Quality Management Team actively works with DHCS and HSAG through participation in DHCS- and HSAG-sponsored trainings, webinars, collaboratives, and meetings to ensure understanding of all EQRO activities and DHCS requirements of Aetna. During the period of July 1, 2018, through June 30, 2019, Aetna's Quality Management Team attended the following: ♦ Quarterly Medi-Cal Managed Care Collaborative Discussions ♦ HSAG Rapid-Cycle PIP Overview Webinar ♦ HSAG Rapid-Cycle PIP training ♦ HSAG HEDIS Compliance Audit-related activities, including on-site audit review ♦ DHCS Quality Improvement Toolkit training ♦ DHCS Quality Improvement Program Changes training ♦ CAHPS Calls ♦ Training for Revised PDSA Worksheet

2017–18 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	♦ DHCS Stakeholder Advisory Committee Meetings ♦ Value-Based Payment Program Measures training In addition to formal/organized trainings and collaboratives, Aetna has reached out to the DHCS quality nurse consultant and HSAG for consultation and technical assistance as needed to ensure understanding of DHCS and EQRO activities and requirements. Summary of audit activities: ♦ DHCS A&I conducted a Focused Medical Audit of Aetna in April 2018, which resulted in no quality-related findings. ♦ DHCS and the Department of Managed Health Care (DMHC) simultaneously conducted a Medical Audit in April 2019. DMHC had no findings related to quality. DHCS results are pending. ♦ Aetna successfully completed the HEDIS Compliance Audit in June 2019. ♦ The CAHPS survey was completed.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Aetna's self-reported actions in Table 8.1 and determined that Aetna adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. Aetna described in detail actions taken during the review period to ensure full understanding of all EQRO activities and DHCS' requirements of the MCP related to each activity.

2018–19 Recommendations

Based on the overall assessment of Aetna's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the MCP.

In the next annual review, HSAG will evaluate continued successes of Aetna.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix C:
Performance Evaluation Report
AIDS Healthcare Foundation
July 1, 2018–June 30, 2019

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Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted SHP, AIDS Healthcare Foundation ("AHF" or "the SHP"). The purpose of this appendix is to provide SHP-specific results of each activity and an assessment of the SHP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this SHP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in AHF's 2019–20 SHP-specific evaluation report. This SHP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Specialty Health Plan Overview

AHF is an SHP operating in Los Angeles County, providing services primarily to beneficiaries living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Due to AHF's unique membership, some of SHP's contracted requirements are different from MCP contract requirements. AHF became operational in Los Angeles County to provide MCMC services effective April 1995. As of June 2019, AHF had 596 beneficiaries.[1]

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Specialty Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent review conducted for AHF. The review description may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical Audit of AHF. A&I conducted the audit from January 22, 2019, through January 31, 2019. A&I evaluated four categories of performance—Utilization Management, Access and Availability of Care, Member's Rights, and Quality Management. Note that DHCS sent AHF its final response to the SHP's CAP on December 3, 2019, which is outside the review period for this report. HSAG includes the information because it reflects full resolution of all findings from the January 2019 A&I Medical Audit.

Table 2.1—DHCS A&I Medical Audit of AHF
Audit Review Period: October 1, 2017, through September 30, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP imposed and findings in this category rectified.
Access and Availability of Care	Yes	CAP imposed and findings in this category rectified.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	Yes	CAP imposed and findings in this category rectified.

Strengths—Compliance Reviews

AHF's CAP response regarding the findings in all four evaluated categories from the January 2019 A&I Medical Audit resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

AHF has no outstanding findings from the January 2019 A&I Medical Audit of the SHP; therefore, HSAG has no recommendations for the SHP in the area of compliance reviews.

3. Specialty Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for AIDS Healthcare Foundation* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that AHF followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results

After validating the SHP's performance measure rates, HSAG assessed the results. See Table 3.1 for AHF's performance measure results for reporting years 2017 through 2019. The reporting year is the year in which the SHP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1:

- Due to changes that the National Committee for Quality Assurance (NCQA) made to the specifications for the *Colorectal Cancer Screening* measure in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing AHF's performance across years or when comparing AHF's results to benchmarks related to this measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although AHF reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.1. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold AHF accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require AHF to submit an IP if the rate for this measure was below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of AHF's performance.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- To assess performance for each SHP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires SHPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless SHPs are reporting the rates for the first time).
  - IPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.
- For all reporting years displayed, the high performance levels and minimum performance levels for the *Colorectal Cancer Screening* measure represent the NCQA Quality Compass®[4] Commercial health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 9 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Specialty Health Plan Performance Measures").

Table 3.1—Multi-Year Performance Measure Results
AHF—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing SHP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

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

Measure	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Colorectal Cancer Screening^*	58.26%	58.45%	56.41%	-2.04
Controlling High Blood Pressure	—	—	56.86%	Not Comparable

Performance Measure Findings

The *Colorectal Cancer Screening* measure rate showed no statistically significant changes from reporting year 2018 and reporting year 2019, and the rate was between the high performance level and minimum performance level in reporting year 2019.

Strengths—Performance Measures

The HSAG auditor determined that AHF followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Opportunities for Improvement—Performance Measures

Based on AHF's reporting year 2019 performance measure results, HSAG has no recommendations for the SHP in the area of performance measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, AHF conducted two SHP-specific PIPs. In this report, HSAG includes summaries of the SHP's PIP module submissions as well as validation findings from the review period.

2017–19 Colorectal Cancer Screening Performance Improvement Project

AHF selected colorectal cancer screening as one of its PIP topics based on its SHP-specific data.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—AHF *Colorectal Cancer Screening* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of colorectal cancer screening among beneficiaries 50 to 75 years of age residing in Los Angeles County	58.26%	70.50%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the SHP's *Colorectal Cancer Screening* PIP. Upon initial review of the module, HSAG determined that AHF met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Including all required components of the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

AHF incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the SHP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the SHP's *Colorectal Cancer Screening* PIP, HSAG reviewed and provided feedback to AHF on the Plan portion of the PDSA cycle for the intervention that the SHP selected to test. HSAG indicated to AHF that the SHP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the intervention that AHF tested for its *Colorectal Cancer Screening* PIP. The table also indicates the key drivers and failure modes that the intervention addressed.

Table 4.2—AHF *Colorectal Cancer Screening* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Provide beneficiaries with supplemental education materials on colorectal cancer screening and offer a gift card for screening completion.	♦ Beneficiary engagement. ♦ Beneficiary does not find value in undergoing a colorectal cancer screening.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to AHF and conducted technical assistance calls with the SHP staff to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although AHF completed testing the intervention through the SMART Aim end date of June 30, 2019, the SHP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this SHP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in AHF's 2019–20 SHP-specific evaluation report.

2017–19 Diabetes Retinal Eye Exam Performance Improvement Project

AHF selected diabetes retinal eye exam as another one of its PIP topics based on its SHP-specific data.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—AHF *Diabetes Retinal Eye Exam* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of retinal eye exams among beneficiaries 18 to 75 years of age residing in Los Angeles County	38.64%	57.00%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the SHP's *Diabetes Retinal Eye Exam* PIP. Upon initial review of the module, HSAG determined that AHF met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Including all required components of the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, AHF incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the SHP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the SHP's *Diabetes Retinal Eye Exam* PIP, HSAG reviewed and provided feedback to AHF on the Plan portion of the PDSA cycle for the intervention that the SHP selected to test. HSAG indicated to AHF that the SHP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the intervention that AHF tested for its *Diabetes Retinal Eye Exam* PIP. The table also indicates the key drivers and failure modes that the intervention addressed.

Table 4.4—AHF *Diabetes Retinal Eye Exam* PIP Intervention Testing

Intervention	Key Drivers and/or Failure Modes Addressed
Provide beneficiaries with supplemental education materials on retinal eye exams and offer gift cards for exam completion.	♦ Beneficiary engagement. ♦ Beneficiary does not find value in undergoing a retinal eye exam.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to AHF and conducted technical assistance calls with SHP staff members to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although AHF completed testing the intervention through the SMART Aim end date of June 30, 2019, the SHP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this SHP-specific evaluation report. Therefore, HSAG includes no

outcomes information in this report. HSAG will include a summary of the PIP outcomes in AHF's 2019–20 SHP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, AHF submitted all required documentation and met all criteria for PIP modules that the SHP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on AHF's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Consumer Surveys

DHCS periodically evaluates the perceptions and experiences of beneficiaries as part of its process for assessing the quality of health care services. For full-scope MCPs, DHCS contracted with HSAG during the July 1, 2018, through June 30, 2019, reporting period to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[5] survey instruments.

SHPs are not included in the CAHPS surveys that HSAG conducts and are instead required to administer their own annual consumer satisfaction surveys to evaluate beneficiary satisfaction regarding care and services provided.

While HSAG reviewed the information submitted by AHF to DHCS for the most recent consumer survey conducted for the SHP, the purpose of HSAG's review was to confirm the SHP conducted the survey as required, not to analyze the survey results or identify opportunities for improvement. The following is a brief summary of the consumer survey conducted for AHF, including the notable high-level results.

Consumer Surveys Conducted for AIDS Healthcare Foundation

AHF contracted with Decision Support Systems (DSS) Research to conduct a CAHPS survey in 2018. DSS conducted the CAHPS 5.0 Adult Medicaid survey, which included the following objectives:

- Determination of beneficiary ratings of the following:
  - Health Plan Overall
  - Health Care Overall
  - Personal Doctor Overall
  - Specialist Overall
- Assessment of beneficiary perceptions related to the following:
  - Customer Service
  - Getting Needed Care
  - Getting Care Quickly
  - How Well Doctors Communicate
  - Shared Decision Making
  - Health Promotion and Education
  - Coordination of Care

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

- Measurement of the percentage of beneficiaries who receive flu shots or sprays
- Evaluation of assistance with smoking and tobacco use cessation measures
- Standard measurement of all areas mentioned to facilitate meaningful comparisons among participating health plans

Results—Consumer Surveys

HSAG reviewed AHF's 2018 CAHPS survey report and identified the following notable results from the 2018 survey:

- Using a 0 to 10 scale, with 0 representing "Worst health plan possible" and 10 presenting "Best health plan possible," 73.40 percent of respondents gave AHF a health plan rating of 8, 9, or 10. These results were not significantly different from the 2016 and 2017 results.
- DSS Research identified no significant improvements in the overall ratings or composite scores when compared to the 2016 and 2017 ratings and scores.

6. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with AHF, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 7.1 provides EQR recommendations from AHF's July 1, 2017, through June 30, 2018, SHP-specific evaluation report, along with the SHP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of AHF's self-reported actions.

Table 7.1—AHF's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, SHP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to AHF	Self-Reported Actions Taken by AHF during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Continue monitoring adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2015–17 *Hypertension* and *Viral Load Suppression* PIPs.	The median for *Viral Load Suppression* (75 percent) was established based on the first five quarters of data. The last 21 quarters, which have a mean of 86 percent, demonstrate a run above the median. Special cause variation is established and suggests an improvement trend which identifies a change in process or outcome that is not due to chance. With the advent of such effective HIV medication and good adherence to both medication and appointments, high viral load suppression rates continue to improve. Strong case management keeps members engaged. Hypertension rates have continued to be a focus for the SHP. During 2018 alone the quality department performed 12 in-person visits to health care centers to conduct trainings regarding HEDIS measures. For hypertension we provided workflow suggestions to providers if the first blood pressure reading was high. The recommendation was to take the reading more than once if it was high upon arrival, in order to

2017–18 External Quality Review Recommendations Directed to AHF	Self-Reported Actions Taken by AHF during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	allow the member's blood pressure to go down. Another suggestion to the provider was documentation improvement to ensure all readings are properly input into the electronic health record. Quality staff members performed 18 HEDIS presentations for various audiences including all providers, nursing staff, and our Department of Medicine and Executive Oversight Committee. Care gap lists were distributed to health care centers and care managers to alert providers about which members were noncompliant for HEDIS measures at the time of distribution.

Assessment of SHP's Self-Reported Actions

HSAG reviewed AHF's self-reported actions in Table 7.1 and determined that AHF adequately addressed HSAG's recommendations from the SHP's July 1, 2017, through June 30, 2018, SHP-specific evaluation report. AHF described how the SHP continued monitoring adapted interventions and outcomes from the 2015–17 *Hypertension* and *Viral Load Suppression* PIPs and the SHP's continued efforts to facilitate ongoing improvement.

2018–19 Recommendations

Based on the overall assessment of AHF's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the SHP.

In the next annual review, HSAG will evaluate continued successes of AHF.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix D:
Performance Evaluation Report
Alameda Alliance for Health
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Alameda Alliance for Health ("AAH" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in AAH's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

AAH is a full-scope MCP delivering services to beneficiaries as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in AAH, the Local Initiative MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan.

AAH became operational in Alameda County to provide MCMC services effective 1996. As of June 2019, AAH had 252,056 beneficiaries.[1] This represents 81 percent of the beneficiaries enrolled in Alameda County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for AAH. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of AAH. A&I conducted the audits from June 11, 2018, through June 22, 2018.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of AAH
Audit Review Period: June 1, 2017, through May 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	Yes	CAP in process and under review.
State Supported Services	Yes	CAP in process and under review.

Opportunities for Improvement—Compliance Reviews

AAH has the opportunity to work with DHCS to ensure that the MCP resolves all findings from the June 2018 A&I Medical and State Supported Services Audits. A&I identified findings in all categories, and the findings cut across the areas of quality and timeliness of, and access to, health care.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for Alameda Alliance for Health* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that AAH followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for AAH's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
AAH—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	66.42%	74.45%	73.97%	77.62%	3.65
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**92.61%**	**92.00%**	**91.90%**	93.94%	2.04

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**84.00%**	**84.40%**	**84.53%**	85.60%	1.07
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**86.97%**	**87.19%**	**87.55%**	88.20%	0.65
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**84.60%**	**84.75%**	**85.54%**	86.96%	1.42
Immunizations for Adolescents—Combination 2	—	30.17%	47.69%	55.23%	7.54
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	65.69%	79.56%	74.45%	82.69%	8.24

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	60.10%	74.70%	76.01%	80.30%	4.29
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.61%	73.13%	79.27%	73.84%	-5.43

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
AAH—Alameda County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	5	40.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	4	25.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	5	40.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
AAH—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	62.52%	63.88%	63.93%	0.05
Cervical Cancer Screening	**51.09%**	60.34%	60.00%	63.54%	3.54
Prenatal and Postpartum Care—Postpartum Care	59.61%	67.15%	68.31%	72.78%	4.47
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**73.97%**	84.43%	85.52%	84.44%	-1.08

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
AAH—Alameda County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
AAH—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**84.27%**	86.06%	86.52%	86.95%	0.43
Annual Monitoring for Patients on Persistent Medications—Diuretics	**83.22%**	**85.14%**	85.60%	**85.92%**	0.32
*Asthma Medication Ratio^*	—	60.65%	62.85%	64.17%	1.32
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	58.64%	61.56%	61.80%	67.15%	5.35
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	49.64%	55.23%	58.64%	61.31%	2.67

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	48.42%	50.12%	53.77%	57.66%	3.89
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	40.63%	37.96%	34.31%	29.68%	-4.63
*Comprehensive Diabetes Care—HbA1c Testing^*	83.21%	85.89%	87.59%	89.05%	1.46
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	88.08%	88.81%	89.54%	**86.62%**	-2.92
Controlling High Blood Pressure	—	—	—	64.23%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
AAH—Alameda County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	9	11.11%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	2	9	22.22%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	9	22.22%

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
AAH—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	60.05	46.02	44.64	43.32	Not Tested

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	286.41	253.95	278.91	285.24	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	32.80%	38.05%	41.23%	41.47%	0.24
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	1.18%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	66.76%	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	17.20%	Not Comparable
Use of Imaging Studies for Low Back Pain	83.45%	76.28%	81.99%	80.40%	-1.59

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
AAH—Alameda County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	2	50.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of AAH's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
AAH—Alameda County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	4	19	21.05%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	19	10.53%

Improvement Plan Requirements for 2019

While the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate was below the minimum performance level in reporting year 2019, DHCS will not require AAH to submit an IP for this measure based on DHCS not requiring MCPs to report rates for this measure in reporting year 2020.

Additionally, while the rate for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure was below the minimum performance level in reporting year 2019, DHCS will not require the MCP to submit an IP for this measure due to the small range of variation between the high performance level and minimum performance level thresholds for this measure.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table AAH—Alameda County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.12.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	150.09	84.58	81.35	76.44	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	507.83	480.14	514.87	524.26	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.44%	87.70%	88.99%	89.87%	0.88
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.89%	87.57%	88.90%	88.71%	-0.19
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	97.37%	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	92.52%	89.94%	89.07%	88.67%	-0.40
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	93.82%	88.81%	89.48%	90.89%	1.41

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	86.62%	84.38%	85.23%	85.69%	0.46
*Plan All-Cause Readmissions***	—	—	—	21.09%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table AAH—Alameda County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	51.93	41.83	40.73	39.81	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	266.44	229.36	253.81	259.97	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.44%	84.95%	85.05%	85.24%	0.19
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.06%	83.39%	83.53%	84.17%	0.64
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	92.55%	91.93%	91.92%	93.90%	1.98
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.85%	84.27%	84.43%	85.53%	1.10
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.75%	87.12%	87.47%	88.09%	0.62

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.53%	84.77%	85.55%	87.02%	1.47
*Plan All-Cause Readmissions***	—	—	—	14.35%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations AAH—Alameda County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	76.44	39.81	Not Tested	43.32
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	524.26	259.97	Not Tested	285.24
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.87%	85.24%	4.63	86.95%
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.71%	84.17%	4.54	85.92%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	93.90%	Not Comparable	93.94%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	88.67%	85.53%	3.14	85.60%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	90.89%	88.09%	2.80	88.20%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	85.69%	87.02%	-1.33	86.96%
*Plan All-Cause Readmissions***	21.09%	14.35%	6.74	17.20%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that AAH stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, AAH had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the *Children and Adolescents' Access to*

Primary Care Practitioners—12–24 Months, *25 Months–6 Years*, and *12–19 Years* measures.

- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year non-SPD rates for the following measures:
    - Both *Annual Monitoring for Patients on Persistent Medications* measures
    - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *7–11 Years*
  - The reporting year 2019 SPD rate was significantly worse than the reporting year non-SPD rate for the *Plan All-Cause Readmissions* measure. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that AAH followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for AAH:

- The MCP exceeded the high performance level for the following four of 19 measures (21 percent):
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
  - *Immunizations for Adolescents—Combination 2*. The rate for this measure improved significantly from reporting year 2018 to reporting year 2019.
  - *Use of Imaging Studies for Low Back Pain*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total*. The MCP performed above the high performance level for this measure for the third consecutive year.
- In addition to the rate improving significantly from reporting year 2018 to reporting year 2019 for the *Immunizations for Adolescents—Combination 2* measure, the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* measure rate improved significantly from reporting year 2018 to reporting year 2019.

Opportunities for Improvement—Performance Measures

The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate was below the minimum performance level in reporting year 2019. While the MCP has opportunities for improvement related to this measure, HSAG makes no formal recommendations to the MCP because DHCS will not require the MCP to report the measure to DHCS in reporting year 2020, and DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCP's quality improvement actions related to the measure.

The *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure rate also was below the minimum performance level in reporting year 2019; however, HSAG makes no formal recommendations to the MCP related to this measure due to the small range of variation between the high performance level and minimum performance level thresholds for the measure.

DHCS and HSAG expect that the MCP will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCP will conduct improvement activities, as applicable, related to the *Annual Monitoring for Patients on Persistent Medications—Diuretics* and *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, AAH conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required AAH to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, AAH identified diabetes HbA1c testing among the African-American male population as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—AAH *Diabetes HbA1c Testing* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of HbA1c testing among African-American males ages 18 to 75 in Alameda County	73.12%	79.00%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Diabetes HbA1c Testing* Disparity PIP. Upon initial review of the module, HSAG determined that AAH met all validation criteria for Module 3 in its initial submission.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Diabetes HbA1c Testing* Disparity PIP, HSAG reviewed and provided feedback to AAH on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to AAH that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the interventions that AAH tested for its *Diabetes HbA1c Testing* Disparity PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

Table 4.2—AAH *Diabetes HbA1c Testing* Disparity PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Conduct point-of-care HbA1c testing during primary care visits.	♦ Meaningful beneficiary engagement. ♦ Convenience and ease of access. ♦ Beneficiaries understand the need for HbA1c testing but do not prioritize it. ♦ Beneficiaries leave after their primary care provider (PCP) appointments without going to the lab.
Call noncompliant beneficiaries to educate them on the need for HbA1c testing, address any barriers, and schedule a convenient time for a lab draw.	♦ Meaningful beneficiary engagement. ♦ Beneficiaries understand the need for HbA1c testing but do not prioritize it. ♦ Beneficiaries are inconsistently provided with information on the importance of or need for their HbA1c testing.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to AAH and conducted technical assistance calls with the MCP staff members to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although AAH completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in AAH's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required AAH to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. However, based on AAH demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. AAH selected children's and adolescents' access to primary care physicians as its 2017–19 DHCS-priority PIP topic based on its MCP-specific data.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—AAH *Children/Adolescent Access to Primary Care Physicians* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of primary care visits among beneficiaries ages 12 to 19 who are assigned to partnering clinics	81.12%	86.00%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the MCP's *Children/Adolescent Access to Primary Care Physicians* PIP. Upon initial review of the module, HSAG determined that AAH met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, AAH incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Children/Adolescent Access to Primary Care Physicians* PIP, HSAG reviewed and provided feedback to AAH on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to AAH that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the intervention that AAH tested for its *Children/Adolescent Access to Primary Care Physicians* PIP. The table also indicates the key drivers and failure modes that the intervention addressed.

Table 4.4—AAH *Children/Adolescent Access to Primary Care Physicians* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Outreach to beneficiaries and provide an incentive to promote adolescent well-care visits.	♦ Lack of education around the need for preventive care. ♦ Lack of motivation to seek care.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to AAH to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although AAH completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in AAH's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, AAH submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on AAH's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[6] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with AAH, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from AAH's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of AAH's self-reported actions.

Table 8.1—AAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2015–17 *Prenatal Visits* and *Postpartum Care* PIPs. Additionally, apply lessons learned from these PIPs to facilitate improvement of the adapted interventions.	Since submission of the results of the HSAG 2015–17 *Prenatal Visits* and *Postpartum Care* PIPs, AAH's quality improvement obstetric case managers continued to assist identified members with coordination and management of their prenatal and postpartum care through June 2018. Member interventions included but were not limited to conducting telephonic initial perinatal assessments, coordinating obstetric clinic appointments and transportation services as needed, scheduling in-person interpreter services, requesting medical records coordination between obstetric providers and PCPs, assisting with selecting a PCP, monitoring care plan adherence, and facilitating breast pump orders, as necessary. As a continuous quality improvement focus, the AAH health education team continues to send AAH members health education materials related to prenatal and postpartum care. The AAH quality improvement team continues to facilitate quarterly meetings with AAH perinatal providers to discuss

<table>
<tr><th>2017–18 External Quality Review Recommendations Directed to AAH</th><th>Self-Reported Actions Taken by AAH during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations</th></tr>
<tr><td></td><td>obstetric care and identify best practices as well as opportunities for improvement.

Prenatal and Postpartum Care

<table><tr><th>Measure</th><th>HEDIS Rate Measurement Year 2018</th></tr><tr><td>Prenatal and Postpartum Care—Timeliness of Prenatal Care</td><td>84.44%
50th percentile</td></tr><tr><td>Prenatal and Postpartum Care—Postpartum Care</td><td>72.78%
75th percentile</td></tr></table></td></tr>
</table>

Assessment of MCP's Self-Reported Actions

HSAG reviewed AAH's self-reported actions in Table 8.1 and determined that AAH adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. AAH described how the MCP monitored the adapted interventions to achieve optimal outcomes beyond the life of the 2015–17 *Prenatal Visits* and *Postpartum Care* PIPs. Additionally, the MCP described how it applied and will continue to apply lessons learned from the interventions to facilitate improvement.

2018–19 Recommendations

Based on the overall assessment of AAH's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that the MCP resolve all findings from the June 2018 A&I Medical and State Supported Services Audits of AAH.

In the next annual review, HSAG will evaluate continued successes of AAH as well as the MCP's progress with this recommendation.

Appendix E:
Performance Evaluation Report
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
July 1, 2018–June 30, 2019

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Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan ("Anthem" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in Anthem's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Anthem, formerly Blue Cross of California prior to April 1, 2008, operated in 28 counties during the July 1, 2018, through June 30, 2019, review period for this report. Anthem, a full-scope MCP, delivers care to beneficiaries under the Two-Plan Model (TPM) in eight counties, the Regional model in 18 counties, the Geographic Managed Care (GMC) model in one county, and the San Benito model in one county.

Anthem became operational in Sacramento County to provide MCMC services effective in 1994, with expansion into additional counties occurring in subsequent years—Alameda, Contra Costa, Fresno, San Francisco, and Santa Clara counties in 1996 and Tulare County in 2005. Anthem expanded into Kings and Madera counties in March 2011 and continued providing services in Fresno County under a new contract covering Fresno, Kings, and Madera counties. As part of the expansion authority under Section 1115 of the Social Security Act, MCMC expanded into several rural eastern counties of California in 2013. Under the expansion, Anthem contracted with DHCS to provide MCMC services in Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba counties beginning November 1, 2013.

Anthem's Two-Plan Model

Anthem delivers services to beneficiaries as a "Local Initiative" MCP and commercial plan under the TPM. Table 1.1 shows the counties in which Anthem provided services to beneficiaries under the TPM and denotes for each county which MCP is the commercial plan and which is the Local Initiative.

Table 1.1—Anthem Counties Under the Two-Plan Model

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

Anthem's Geographic Managed Care Model

The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county). Anthem operates in Sacramento County under the GMC model.

In addition to Anthem, Sacramento County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Health Net Community Solutions, Inc.
- Kaiser NorCal
- Molina Healthcare of California Partner Plan, Inc.

Anthem's Regional Model

Anthem delivers services to its beneficiaries under the Regional model in Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba counties. The other MCPs operating under the Regional model are California Health & Wellness Plan and Kaiser NorCal. California Health & Wellness Plan operates in all 18 counties; and Kaiser NorCal operates in Amador, El Dorado, and Placer counties. Beneficiaries may enroll in Anthem or in the alternative commercial plan in the respective counties.

Anthem's Enrollment

Table 1.2 shows the number of beneficiaries for Anthem for each county, the percentage of Anthem's beneficiaries enrolled in the county, and the MCP's total number of beneficiaries as of June 2019.[1]

Table 1.2—Anthem Enrollment as of June 2019

County	Anthem Enrollment as of June 2019	Percentage of Anthem Beneficiaries Enrolled in the County
Alameda	58,759	19%
Alpine	139	64%
Amador	4,676	77%

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

County	Anthem Enrollment as of June 2019	Percentage of Anthem Beneficiaries Enrolled in the County
Butte	23,203	37%
Calaveras	4,118	44%
Colusa	4,668	60%
Contra Costa	26,319	13%
El Dorado	8,262	29%
Fresno	105,901	27%
Glenn	2,653	27%
Inyo	1,881	51%
Kings	19,257	40%
Madera	19,502	35%
Mariposa	3,086	78%
Mono	1,539	62%
Nevada	11,353	57%
Placer	27,379	61%
Plumas	2,580	50%
Sacramento	177,334	41%
San Benito	7,834	100%
San Francisco	18,113	13%
Santa Clara	66,324	22%
Sierra	329	58%
Sutter	21,011	67%
Tehama	8,169	42%
Tulare	92,167	45%
Tuolumne	4,764	47%
Yuba	15,655	63%
Total	**736,975**	

Note: DHCS allows Anthem to combine data from multiple counties to make up single reporting units for Region 1 and Region 2. The counties within each of these reporting units are as follows:

- Region 1—Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama counties
- Region 2—Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba counties

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Anthem. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Anthem. A&I conducted the audits from October 29, 2018, through November 9, 2018. During the audits, A&I examined Anthem's documentation for compliance and the extent to which the MCP had operationalized its CAP from the previous audits.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Anthem
Audit Review Period: October 1, 2017, through September 30, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	No	No findings.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Follow-Up on 2017 Department of Health Care Services Medical Audit

A&I conducted an on-site Medical Audit of Anthem from November 6, 2017, through November 17, 2017, covering the review period of November 1, 2016, through October 31, 2017. HSAG provided a summary of the survey results and status in Anthem's 2017–18 MCP-specific evaluation report. At the time of this 2018–19 MCP-specific evaluation report publication,

Anthem's CAP from the 2017 audit was still in process. HSAG will provide an update on the status of this CAP in Anthem's 2019–20 MCP-specific evaluation report.

Strengths—Compliance Reviews

A&I identified no findings in the Utilization Management, Access and Availability of Care, Administrative and Organizational Capacity, and State Supported Services categories during the 2018 Medical and State Supported Services Audits of Anthem.

Opportunities for Improvement—Compliance Reviews

Anthem has the opportunity to work with DHCS to ensure that the MCP fully resolves all findings from the 2017 and 2018 A&I Medical and State Supported Services Audits.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for Anthem Blue Cross Partnership Plan* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that Anthem followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.108 for Anthem's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.108:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.96 present the performance measure results and findings by domain, and Table 3.97 through Table 3.108 present the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.
- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 through Table 3.12 present the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1 through Table 3.12:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Anthem—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	66.67%	69.68%	68.86%	67.22%	-1.64
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**88.48%**	**86.91%**	**87.08%**	**86.41%**	-0.67

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**78.86%**	**78.08%**	**82.19%**	**78.25%**	-3.94
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**84.58%**	**82.66%**	**86.04%**	**81.32%**	-4.72
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**80.25%**	**77.34%**	**82.37%**	**80.05%**	-2.32
Immunizations for Adolescents—Combination 2	—	22.22%	39.90%	44.04%	4.14
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	59.95%	71.99%	76.04%	76.12%	0.08

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	53.01%	63.89%	72.40%	71.04%	-1.36
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.44%	69.44%	77.13%	68.13%	-9.00

Table 3.2—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Anthem—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	67.99%	64.94%	73.68%	74.09%	0.41
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**90.76%**	**89.37%**	94.33%	**92.29%**	-2.04
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**83.81%**	**82.28%**	89.86%	**83.45%**	-6.41
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**87.58%**	**85.82%**	89.22%	**86.65%**	-2.57
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**83.87%**	**81.82%**	86.28%	**80.96%**	-5.32
Immunizations for Adolescents—Combination 2	—	21.06%	36.74%	33.33%	-3.41
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	56.94%	71.76%	67.02%	75.78%	8.76

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	51.62%	65.74%	63.56%	75.26%	11.70
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.13%	71.99%	80.41%	79.26%	-1.15

Table 3.3—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Anthem—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	68.52%	70.11%	72.26%	68.66%	-3.60
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**93.71%**	**92.70%**	94.37%	**92.98%**	-1.39
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**84.73%**	**84.44%**	**84.73%**	**83.98%**	-0.75
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**86.11%**	**84.71%**	**84.34%**	**84.02%**	-0.32
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**82.31%**	**80.37%**	**80.19%**	**80.32%**	0.13
Immunizations for Adolescents—Combination 2	—	26.16%	33.82%	34.06%	0.24
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	67.36%	69.66%	66.84%	72.91%	6.07

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	61.57%	64.81%	60.79%	66.58%	5.79
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.60%	72.68%	75.52%	73.48%	-2.04

Table 3.4—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Anthem—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	68.75%	70.90%	68.86%	70.28%	1.42
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**93.92%**	**91.55%**	94.08%	93.89%	-0.19
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.25%	**84.77%**	86.99%	85.45%	-1.54
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**85.42%**	**86.22%**	**85.59%**	**87.45%**	1.86
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**84.75%**	**85.81%**	**84.70%**	85.83%	1.13
Immunizations for Adolescents—Combination 2	—	18.98%	27.01%	34.06%	7.05
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	58.10%	65.89%	69.08%	82.14%	13.06

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	47.22%	58.70%	61.85%	73.72%	11.87
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.85%	72.22%	74.63%	67.64%	-6.99

Table 3.5—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Anthem—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	76.88%	72.27%	76.12%	75.08%	-1.04
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	97.08%	97.40%	97.73%	96.29%	-1.44
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	93.10%	91.91%	90.99%	92.04%	1.05
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	92.61%	93.12%	92.20%	93.26%	1.06
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	89.30%	88.84%	88.97%	89.57%	0.60
Immunizations for Adolescents—Combination 2	—	42.59%	57.42%	59.55%	2.13
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	78.01%	81.69%	83.39%	86.30%	2.91

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	70.60%	75.96%	80.19%	78.52%	-1.67
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	83.48%	84.26%	83.84%	82.08%	-1.76

Table 3.6—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	67.82%	71.95%	65.45%	65.69%	0.24
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	96.56%	96.13%	95.59%	95.80%	0.21
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	88.89%	88.34%	86.53%	84.68%	-1.85
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**88.58%**	89.13%	88.60%	88.04%	-0.56
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**86.28%**	86.32%	**85.32%**	**84.82%**	-0.50
Immunizations for Adolescents—Combination 2	—	18.29%	28.95%	**24.57%**	-4.38
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	**45.14%**	55.32%	61.22%	70.66%	9.44

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	**38.19%**	53.47%	61.71%	69.90%	8.19
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**64.91%**	68.75%	68.37%	69.34%	0.97

Table 3.7—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**56.94%**	65.05%	**60.58%**	**61.27%**	0.69
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**92.37%**	**92.22%**	**92.11%**	**92.44%**	0.33
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**83.55%**	**81.52%**	**81.75%**	**80.86%**	-0.89
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**83.19%**	**83.11%**	**82.98%**	**83.31%**	0.33
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**83.35%**	**81.67%**	**81.86%**	**81.81%**	-0.05
Immunizations for Adolescents—Combination 2	—	20.37%	28.71%	27.98%	-0.73
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	**51.85%**	61.34%	63.07%	66.07%	3.00

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	44.91%	59.72%	61.81%	64.29%	2.48
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**62.50%**	65.51%	66.42%	69.81%	3.39

Table 3.8—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Anthem—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**62.04%**	66.67%	65.69%	**63.56%**	-2.13
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	91.18%	91.24%	91.42%	91.98%	0.56
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**81.28%**	79.09%	79.24%	**82.18%**	2.94
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	84.32%	82.57%	82.36%	**82.12%**	-0.24
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	80.44%	79.32%	79.45%	80.30%	0.85
Immunizations for Adolescents—Combination 2	—	23.38%	33.58%	37.47%	3.89
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	67.59%	72.92%	76.05%	80.75%	4.70

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	53.24%	64.12%	70.53%	78.74%	8.21
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.97%	71.53%	66.67%	71.05%	4.38

Table 3.9—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Anthem—San Benito County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	67.43%	72.41%	**63.13%**	**60.27%**	-2.86
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**92.50%**	**91.89%**	94.06%	**92.57%**	-1.49
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**84.97%**	**83.54%**	**83.84%**	**82.20%**	-1.64
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**86.12%**	**84.41%**	**84.64%**	**83.93%**	-0.71
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**82.26%**	**78.65%**	**80.82%**	**80.71%**	-0.11
Immunizations for Adolescents—Combination 2	—	14.29%	25.84%	**23.63%**	-2.21
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	53.60%	61.57%	61.23%	64.09%	2.86

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	**42.46%**	56.71%	58.02%	62.34%	4.32
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**64.35%**	65.66%	71.01%	**63.50%**	-7.51

Table 3.10—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Anthem—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	72.39%	75.78%	76.80%	72.04%	-4.76
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.26%	93.30%	96.76%	99.39%	2.63
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**84.12%**	85.28%	85.44%	**83.97%**	-1.47
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.98%	89.16%	88.08%	**86.78%**	-1.30
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.06%	87.38%	87.19%	86.18%	-1.01
Immunizations for Adolescents—Combination 2	—	31.71%	38.40%	46.23%	7.83
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	72.22%	77.78%	78.03%	75.40%	-2.63

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	68.75%	76.16%	75.08%	75.08%	0.00
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.28%	76.29%	75.67%	70.93%	-4.74

Table 3.11—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Anthem—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	70.83%	73.77%	71.95%	76.16%	4.21
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**91.29%**	**91.43%**	**92.06%**	**90.45%**	-1.61
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**82.62%**	**82.23%**	**83.01%**	84.42%	1.41
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**86.48%**	**85.83%**	**85.41%**	**85.64%**	0.23
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**84.22%**	**80.77%**	**82.05%**	**82.75%**	0.70
Immunizations for Adolescents—Combination 2	—	27.55%	38.69%	43.80%	5.11
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	65.51%	73.61%	72.63%	76.33%	3.70

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	53.94%	64.12%	65.53%	70.48%	4.95
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.21%	75.46%	73.97%	76.22%	2.25

Table 3.12—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Anthem—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	69.74%	72.69%	81.75%	75.67%	-6.08
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	97.29%	96.62%	96.93%	96.97%	0.04
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	91.69%	90.61%	90.11%	89.68%	-0.43
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.83%	91.69%	91.53%	91.72%	0.19
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	90.69%	90.25%	90.01%	90.54%	0.53
Immunizations for Adolescents—Combination 2	—	29.63%	37.47%	45.50%	8.03
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	74.54%	77.25%	81.19%	81.60%	0.41

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	68.75%	72.75%	78.51%	76.04%	-2.47
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.57%	79.17%	84.59%	69.34%	-15.25

Table 3.13 through Table 3.24 present findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.13 through Table 3.24:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.13—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Alameda County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.14—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Contra Costa County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	5	40.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.15—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Fresno County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.16—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Kings County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	5	60.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.17—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Madera County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	3	5	60.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	4	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.18—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	5	40.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	5	20.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	5	20.00%

Table 3.19—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	5	20.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	4	0.00%

Table 3.20—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Sacramento County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	5	20.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	5	20.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	5	20.00%

Table 3.21—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—San Benito County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	5	60.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	4	50.00%

Table 3.22—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—San Francisco County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.23—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Santa Clara County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.24—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Tulare County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	5	40.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Assessment of Improvement Plans—Preventive Screening and Children's Health

Based on reporting year 2018 performance measure results, DHCS required Anthem to submit an IP to address the MCP's performance below the minimum performance level for the *Childhood Immunization Status—Combination 3* measure in Region 2 and San Benito County.

For the *Childhood Immunization Status—Combination 3* measure, Anthem partnered with a provider in San Benito County to test whether educating the provider on data reconciliation between the provider's electronic health records (EHRs) and the California Immunization Registry would improve the MCP's performance on this measure. Anthem indicated that the provider's *Childhood Immunization Status—Combination 3* measure rate improved across measurement periods due to the provider improving accuracy and timeliness of data entry. Anthem reported learning that setting up a data exchange with the California Immunization Registry eliminates the need to manually enter vaccines into EHRs and helps to eliminate data entry errors and components of combination vaccines being missed.

The *Childhood Immunization Status—Combination 3* measure rates in Region 2 and San Benito County remained below the minimum performance level in reporting year 2019.

Preventive Screening and Women's Health

Table 3.25 through Table 3.36 present the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.25 through Table 3.36:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.25—Preventive Screening and Women's Health Domain Multi-Year Performance Measure Results Anthem—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**51.34%**	53.37%	**51.71%**	-1.66
Cervical Cancer Screening	**43.46%**	50.58%	**49.15%**	**48.91%**	-0.24
Prenatal and Postpartum Care—Postpartum Care	**52.56%**	57.08%	**58.88%**	64.34%	5.46
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**75.81%**	76.10%	82.00%	83.54%	1.54

Table 3.26—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Anthem—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**42.98%**	**47.43%**	**49.07%**	1.64
Cervical Cancer Screening	**41.07%**	**43.49%**	**50.12%**	57.18%	7.06
Prenatal and Postpartum Care—Postpartum Care	**49.13%**	56.62%	72.30%	67.16%	-5.14
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.08%	79.45%	87.32%	84.31%	-3.01

Table 3.27—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Anthem—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**45.16%**	**44.50%**	**43.75%**	-0.75
Cervical Cancer Screening	**46.17%**	49.42%	**49.15%**	**51.58%**	2.43
Prenatal and Postpartum Care—Postpartum Care	**51.87%**	61.34%	72.19%	67.16%	-5.03
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**68.46%**	78.47%	82.91%	80.90%	-2.01

Table 3.28—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Anthem—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**48.32%**	**50.39%**	**50.73%**	0.34
Cervical Cancer Screening	**46.40%**	49.42%	**48.91%**	54.50%	5.59
Prenatal and Postpartum Care—Postpartum Care	**52.13%**	**52.63%**	62.09%	61.83%	-0.26
Prenatal and Postpartum Care—Timeliness of Prenatal Care	81.56%	78.95%	88.96%	86.39%	-2.57

Table 3.29—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Anthem—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	54.47%	54.96%	53.20%	-1.76
Cervical Cancer Screening	**50.47%**	53.83%	53.53%	63.17%	9.64
Prenatal and Postpartum Care—Postpartum Care	**52.16%**	60.47%	61.32%	69.34%	8.02
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**71.98%**	75.58%	81.48%	83.97%	2.49

Table 3.30—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**49.65%**	**45.28%**	**48.56%**	3.28
Cervical Cancer Screening	**43.16%**	49.16%	**51.09%**	54.99%	3.90
Prenatal and Postpartum Care—Postpartum Care	67.98%	70.65%	69.54%	63.26%	-6.28
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.15%	87.01%	84.77%	85.40%	0.63

Table 3.31—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**49.20%**	**48.22%**	**50.89%**	2.67
Cervical Cancer Screening	**47.78%**	55.37%	58.39%	55.47%	-2.92
Prenatal and Postpartum Care—Postpartum Care	59.44%	67.94%	67.21%	65.69%	-1.52
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.45%	83.73%	79.23%	84.91%	5.68

Table 3.32—Preventive Screening and Women's Health Domain Multi-Year Performance Measure Results Anthem—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	54.54%	53.61%	55.59%	1.98
Cervical Cancer Screening	**46.73%**	49.53%	53.04%	**53.28%**	0.24
Prenatal and Postpartum Care—Postpartum Care	61.42%	59.12%	65.08%	60.90%	-4.18
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.82%	84.18%	80.90%	85.11%	4.21

Table 3.33—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Anthem—San Benito County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**51.46%**	53.68%	52.94%	-0.74
Cervical Cancer Screening	**44.88%**	50.35%	56.69%	57.42%	0.73
Prenatal and Postpartum Care—Postpartum Care	**38.36%**	67.33%	70.09%	65.74%	-4.35
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**71.23%**	91.09%	86.92%	88.89%	1.97

Table 3.34—Preventive Screening and Women's Health Domain Multi-Year Performance Measure Results Anthem—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	61.03%	59.02%	58.31%	-0.71
Cervical Cancer Screening	**53.99%**	60.24%	56.93%	57.28%	0.35
Prenatal and Postpartum Care—Postpartum Care	57.89%	63.33%	67.14%	67.80%	0.66
Prenatal and Postpartum Care—Timeliness of Prenatal Care	78.95%	86.00%	85.71%	84.75%	-0.96

Table 3.35—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Anthem—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	55.60%	57.39%	58.62%	1.23
Cervical Cancer Screening	**47.10%**	50.82%	**46.96%**	**50.61%**	3.65
Prenatal and Postpartum Care—Postpartum Care	64.90%	68.21%	68.06%	65.21%	-2.85
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.56%	85.85%	83.06%	86.37%	3.31

Table 3.36—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Anthem—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	58.29%	62.56%	60.76%	-1.80
Cervical Cancer Screening	62.41%	62.24%	68.37%	66.94%	-1.43
Prenatal and Postpartum Care—Postpartum Care	63.49%	71.04%	74.45%	69.59%	-4.86
Prenatal and Postpartum Care—Timeliness of Prenatal Care	81.16%	88.37%	83.21%	90.02%	6.81

Table 3.37 through Table 3.48 present findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.37 through Table 3.48: unforgettable

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.37—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	2	50.00%

Table 3.38—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Contra Costa County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.39—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Fresno County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.40—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Kings County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.41—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Madera County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.42—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.43—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	3	66.67%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.44—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Sacramento County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.45—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—San Benito County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.46—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—San Francisco County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.47—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Santa Clara County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.48—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Tulare County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Assessment of Improvement Plans—Preventive Screening and Women's Health

Based on reporting year 2018 performance measure results, DHCS required Anthem to submit IPs for the following measures:

- *Breast Cancer Screening* in Contra Costa County, Fresno County, Kings County, Region 1, and Region 2
- *Cervical Cancer Screening* in Alameda County, Contra Costa County, Fresno County, Kings County, Region 1, and Santa Clara County
- *Prenatal and Postpartum Care—Postpartum Care* in Alameda County

Breast Cancer Screening

Anthem conducted two PDSA cycles to improve the MCP's performance on the *Breast Cancer Screening* measure.

For the first PDSA cycle, Anthem tested whether implementing a supplemental tracking process at a provider site in Amador County would result in more beneficiaries completing their mammograms. The tracking process identified beneficiaries who would receive a follow-up outreach contact from their referring primary care provider (PCP) reminding them to schedule their mammograms.

Based on limited staff resources at the provider site, for the second PDSA cycle Anthem tested whether sending text messages to eligible beneficiaries about scheduling their mammography appointments would result in more beneficiaries completing their mammograms.

Anthem reported learning that due to a claims data lag, claims data should not be the sole source for identifying outcome results following PDSA cycles.

The *Breast Cancer Screening* rates in Contra Costa County, Fresno County, Kings County, Region 1, and Region 2 remained below the minimum performance level in reporting year 2019.

Cervical Cancer Screening

To address Anthem's performance below the minimum performance level for the *Cervical Cancer Screening* measure, DHCS required Anthem to submit a Pilot Quality Improvement Strategy Summary/Progress Report which described the quality improvement strategies that the MCP implemented to improve its performance on the measure. Anthem indicated that it used a texting outreach program which enabled the MCP to notify beneficiaries in a timely manner about upcoming provider clinic days. To increase beneficiary participation in the clinic days, Anthem made sure that female clinicians were available and offered beneficiary incentives following screening completion.

The *Cervical Cancer Screening* measure rates in Contra Costa County, Kings County, and Region 1 improved to above the minimum performance level in reporting year 2019. The *Cervical Cancer Screening* measure rates in Alameda, Fresno, and Santa Clara counties remained below the minimum performance level in reporting year 2019.

Postpartum Care

The *Prenatal and Postpartum Care—Postpartum Care* measure rate in Alameda County was below the minimum performance level in reporting year 2018; however, because Anthem was already conducting a *Postpartum Care* PIP, DHCS did not require the MCP to conduct additional IP activities related to this measure. HSAG includes a summary of Anthem's progress on the *Postpartum Care* PIP in Section 5 of this report ("Performance Improvement Projects").

The *Prenatal and Postpartum Care—Postpartum Care* measure rate in Alameda County improved to above the minimum performance level in reporting year 2019.

Care for Chronic Conditions

Table 3.49 through Table 3.60 present the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.49 through Table 3.60:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.49 through Table 3.60. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.49—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Anthem—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.78%	86.62%	86.29%	87.64%	1.35

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**84.01%**	85.64%	86.38%	86.74%	0.36
*Asthma Medication Ratio^*	—	**53.78%**	**53.37%**	**53.87%**	0.50
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	**47.92%**	58.33%	58.15%	61.31%	3.16
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	47.69%	51.16%	52.80%	54.74%	1.94
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	50.69%	53.94%	53.77%	51.34%	-2.43
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	42.13%	35.65%	34.79%	38.20%	3.41
*Comprehensive Diabetes Care—HbA1c Testing^*	84.26%	85.65%	84.43%	**84.18%**	-0.25
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	84.49%	**86.34%**	**87.83%**	**86.13%**	-1.70
Controlling High Blood Pressure	—	—	—	57.18%	Not Comparable

Table 3.50—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Anthem—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.25%	**84.88%**	**85.61%**	**84.64%**	-0.97

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.07%	**80.00%**	87.57%	**84.30%**	-3.27
*Asthma Medication Ratio^*	—	60.74%	59.80%	60.32%	0.52
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	58.00%	56.25%	61.56%	62.29%	0.73
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	47.33%	47.92%	50.85%	52.31%	1.46
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	49.88%	53.70%	55.23%	49.64%	-5.59
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	39.44%	38.43%	33.58%	38.69%	5.11
*Comprehensive Diabetes Care—HbA1c Testing^*	**80.51%**	84.26%	86.62%	**83.45%**	-3.17
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	84.45%	**88.19%**	88.56%	**84.91%**	-3.65
Controlling High Blood Pressure	—	—	—	57.18%	Not Comparable

Table 3.51—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Anthem—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**83.34%**	85.84%	86.31%	**85.23%**	-1.08

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**84.35%**	85.76%	86.35%	**84.50%**	-1.85
*Asthma Medication Ratio^*	—	55.91%	**54.22%**	**52.07%**	-2.15
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	58.33%	62.27%	63.50%	63.50%	0.00
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	47.45%	53.70%	51.34%	56.93%	5.59
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	47.22%	45.60%	47.20%	48.42%	1.22
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	44.91%	44.21%	41.61%	42.58%	0.97
*Comprehensive Diabetes Care—HbA1c Testing^*	84.03%	86.11%	84.91%	85.40%	0.49
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	89.81%	90.28%	**87.59%**	91.48%	3.89
Controlling High Blood Pressure	—	—	—	54.74%	Not Comparable

Table 3.52—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Anthem—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.33%	86.01%	**84.78%**	**85.43%**	0.65

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**83.44%**	85.67%	**84.27%**	86.98%	2.71
*Asthma Medication Ratio^*	—	55.69%	58.33%	61.33%	3.00
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	62.96%	61.81%	63.75%	63.75%	0.00
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	57.87%	53.94%	57.91%	64.48%	6.57
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	44.44%	45.83%	52.07%	46.72%	-5.35
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	41.90%	42.82%	37.71%	41.61%	3.90
*Comprehensive Diabetes Care—HbA1c Testing^*	85.42%	85.65%	89.29%	88.32%	-0.97
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	90.74%	91.44%	91.00%	90.27%	-0.73
Controlling High Blood Pressure	—	—	—	57.66%	Not Comparable

Table 3.53—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Anthem—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**82.19%**	**83.49%**	**80.75%**	**79.36%**	-1.39

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**79.61%**	85.67%	**84.74%**	**82.39%**	-2.35
*Asthma Medication Ratio^*	—	67.31%	59.27%	59.45%	0.18
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	61.11%	71.30%	69.83%	69.10%	-0.73
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	56.02%	62.96%	65.21%	58.39%	-6.82
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	44.68%	50.93%	49.39%	49.15%	-0.24
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	45.83%	37.04%	40.88%	39.66%	-1.22
*Comprehensive Diabetes Care—HbA1c Testing^*	88.43%	88.19%	88.32%	89.54%	1.22
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	90.97%	90.97%	91.97%	92.21%	0.24
Controlling High Blood Pressure	—	—	—	63.26%	Not Comparable

Table 3.54—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Anthem— Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications— ACE Inhibitors or ARBs	86.15%	85.92%	**85.53%**	**84.87%**	-0.66

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.08%	85.92%	**84.62%**	**84.13%**	-0.49
*Asthma Medication Ratio^*	—	57.25%	59.19%	61.55%	2.36
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	64.35%	67.05%	68.86%	69.34%	0.48
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**44.21%**	51.97%	51.34%	57.18%	5.84
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	49.07%	54.29%	52.07%	55.72%	3.65
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	42.13%	35.50%	36.50%	34.79%	-1.71
*Comprehensive Diabetes Care—HbA1c Testing^*	84.95%	**81.44%**	85.89%	**82.48%**	-3.41
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	85.42%	**85.15%**	**87.10%**	**84.91%**	-2.19
Controlling High Blood Pressure	—	—	—	63.02%	Not Comparable

Table 3.55—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**81.21%**	**83.27%**	**85.22%**	**84.39%**	-0.83

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**83.28%**	**82.66%**	85.58%	86.95%	1.37
*Asthma Medication Ratio^*	—	55.24%	58.10%	59.63%	1.53
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	64.35%	62.73%	66.18%	63.99%	-2.19
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**41.90%**	46.30%	49.64%	54.26%	4.62
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	49.07%	50.69%	54.01%	49.39%	-4.62
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	39.81%	38.89%	36.25%	39.90%	3.65
*Comprehensive Diabetes Care—HbA1c Testing^*	**82.41%**	**82.87%**	85.40%	**83.70%**	-1.70
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	86.81%	**87.96%**	**85.40%**	**84.43%**	-0.97
Controlling High Blood Pressure	—	—	—	55.47%	Not Comparable

Table 3.56—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Anthem—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**84.38%**	**84.90%**	**85.65%**	**85.43%**	-0.22

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.96%	85.34%	**84.74%**	**84.49%**	-0.25
*Asthma Medication Ratio^*	—	**53.01%**	**51.83%**	**52.53%**	0.70
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	56.73%	53.94%	54.99%	61.31%	6.32
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**41.06%**	46.53%	49.15%	55.96%	6.81
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	46.14%	48.38%	46.72%	52.31%	5.59
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	41.50%	38.66%	42.58%	33.82%	-8.76
*Comprehensive Diabetes Care—HbA1c Testing^*	**76.82%**	**81.94%**	**80.05%**	85.40%	5.35
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	90.07%	89.12%	89.05%	91.48%	2.43
Controlling High Blood Pressure	—	—	—	54.26%	Not Comparable

Table 3.57—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Anthem—San Benito County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**84.00%**	85.95%	**82.09%**	**72.11%**	-9.98

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**84.62%**	85.71%	**78.75%**	**74.32%**	-4.43
*Asthma Medication Ratio^*	—	77.36%	68.49%	73.91%	5.42
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	60.58%	59.15%	67.06%	61.93%	-5.13
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	52.55%	48.59%	54.12%	60.23%	6.11
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	**35.77%**	44.37%	**40.59%**	44.89%	4.30
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	**54.74%**	45.77%	45.29%	40.34%	-4.95
*Comprehensive Diabetes Care—HbA1c Testing^*	**73.72%**	**75.35%**	**79.41%**	**82.95%**	3.54
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	86.13%	**81.69%**	89.41%	90.34%	0.93
Controlling High Blood Pressure	—	—	—	58.09%	Not Comparable

Table 3.58—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Anthem—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.27%	89.47%	86.16%	89.12%	2.96

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**82.83%**	85.94%	88.74%	86.96%	-1.78
*Asthma Medication Ratio^*	—	**46.15%**	**48.78%**	**46.92%**	-1.86
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	59.49%	66.44%	63.99%	69.10%	5.11
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	58.10%	57.87%	53.28%	55.23%	1.95
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	53.70%	55.56%	57.42%	59.85%	2.43
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	37.73%	33.10%	32.85%	28.71%	-4.14
*Comprehensive Diabetes Care—HbA1c Testing^*	89.12%	90.05%	84.43%	91.00%	6.57
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	92.13%	88.66%	**87.83%**	89.78%	1.95
Controlling High Blood Pressure	—	—	—	55.96%	Not Comparable

Table 3.59—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Anthem—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.37%	88.31%	88.27%	88.20%	-0.07

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.68%	87.99%	89.37%	88.96%	-0.41
*Asthma Medication Ratio^*	—	56.56%	57.39%	**53.16%**	-4.23
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	56.84%	63.81%	63.26%	64.48%	1.22
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	61.25%	59.40%	60.10%	58.15%	-1.95
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	56.61%	53.36%	61.07%	56.69%	-4.38
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	31.09%	32.71%	29.20%	31.63%	2.43
*Comprehensive Diabetes Care—HbA1c Testing^*	89.79%	86.54%	86.13%	**83.21%**	-2.92
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	86.77%	90.49%	**88.32%**	**85.16%**	-3.16
Controlling High Blood Pressure	—	—	—	56.20%	Not Comparable

Table 3.60—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Anthem—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.32%	87.87%	88.22%	**85.80%**	-2.42

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.83%	86.64%	87.14%	**85.34%**	-1.80
*Asthma Medication Ratio^*	—	57.55%	57.36%	61.53%	4.17
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	62.96%	67.36%	63.99%	63.26%	-0.73
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	51.16%	59.26%	57.18%	63.26%	6.08
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	45.83%	49.31%	53.28%	55.47%	2.19
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	41.20%	39.35%	36.25%	33.82%	-2.43
*Comprehensive Diabetes Care—HbA1c Testing^*	87.50%	91.44%	91.00%	92.70%	1.70
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	93.98%	90.97%	90.75%	91.24%	0.49
Controlling High Blood Pressure	—	—	—	61.56%	Not Comparable

Table 3.61 through Table 3.72 present findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.61 through Table 3.72:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.61—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Anthem—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	2	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	9	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	8	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	7	14.29%

Table 3.62—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Anthem—Contra Costa County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	4	9	44.44%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	8	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	3	8	37.50%

Table 3.63—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Anthem—Fresno County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	2	50.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	9	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	7	28.57%

Table 3.64—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Anthem—Kings County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	2	50.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	9	11.11%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	7	0.00%

Table 3.65—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Anthem—Madera County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	2	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	9	22.22%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	8	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	7	0.00%

Table 3.66—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	3	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	4	9	44.44%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	8	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	6	16.67%

Table 3.67—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	2	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	9	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	2	8	25.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	7	14.29%

Table 3.68—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Anthem—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	4	25.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	9	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	8	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.69—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Anthem—San Benito County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	9	11.11%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	4	25.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	9	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	8	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.70—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Anthem—San Francisco County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	9	22.22%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	2	50.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	9	11.11%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	7	0.00%

Table 3.71—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Anthem—Santa Clara County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	9	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	8	25.00%

Table 3.72—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Anthem—Tulare County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	9	11.11%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	2	9	22.22%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	9	22.22%

Assessment of Improvement Plans—Care for Chronic Conditions

Based on reporting year 2018 performance measure results, DHCS required Anthem to submit IPs for the following measures:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Contra Costa County, Kings County, Madera County, Region 1, Region 2, Sacramento County, and San Benito County
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Kings County, Madera County, Region 1, Sacramento County, and San Benito County
- *Asthma Medication Ratio* in Alameda, Fresno, Sacramento, and San Francisco counties
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in San Benito County
- *Comprehensive Diabetes Care—HbA1c Testing* in Sacramento and San Benito counties
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Alameda County, Fresno County, Region 1, Region 2, San Francisco County, and Santa Clara County

Asthma Medication Ratio

DHCS previously approved that Anthem conduct a PIP to address the MCP's performance below the minimum performance level for the *Asthma Medication Ratio* measure; therefore, DHCS did not require the MCP to conduct additional IP activities related to this measure. HSAG includes a summary of Anthem's progress on the *Asthma Medication Ratio* Disparity PIP in Section 5 of this report ("Performance Improvement Projects").

The *Asthma Medication Ratio* measure rates in Alameda, Fresno, Sacramento, and San Francisco counties remained below the minimum performance level in reporting year 2019.

Laboratory Tests

To address Anthem's performance below the minimum performance levels for the *Annual Monitoring for Patients on Persistent Medications* and *Comprehensive Diabetes Care* measures, DHCS required Anthem to submit a Pilot Quality Improvement Strategy Summary/Progress Report which described the quality improvement strategies that the MCP implemented to improve its performance on the measures.

Anthem tested whether using a beneficiary texting outreach program in the Sacramento area, combined with targeted providers implementing or improving point-of-care testing and a standing lab order process, would improve beneficiaries' completion of needed lab tests. Anthem reported learning that developing collaborative relationships takes time and that during the process, the MCP was able to work successfully with the provider organization's medical director to evaluate the clinic workflow and standing order process.

The rates for the following measures included in the Pilot Quality Improvement Strategy Summary/Progress Report improved to above the minimum performance levels in reporting year 2019:

- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Kings County
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in San Benito County
- *Comprehensive Diabetes Care—HbA1c Testing* in Sacramento County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Fresno and San Francisco counties

The rates for the following measures included in the Pilot Quality Improvement Strategy Summary/Progress Report remained below the minimum performance levels in reporting year 2019:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Contra Costa County, Kings County, Madera County, Region 1, Region 2, Sacramento County, and San Benito County
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Madera County, Region 1, Sacramento County, and San Benito County
- *Comprehensive Diabetes Care—HbA1c Testing* in San Benito County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Alameda County, Region 1, Region 2, and Santa Clara County

Appropriate Treatment and Utilization

Table 3.73 through Table 3.84 present the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.73 through Table 3.84:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.

- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.73—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results Anthem—Alameda County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	51.37	48.13	48.34	47.80	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	170.67	175.42	189.70	188.21	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	41.32%	49.04%	55.07%	59.76%	4.69
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	17.54%	Not Comparable
Use of Imaging Studies for Low Back Pain	82.19%	81.87%	78.57%	81.32%	2.75

Table 3.74—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results Anthem—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and

Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	49.15	44.93	44.94	43.58	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	167.21	169.14	193.34	202.22	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	53.66%	62.03%	60.94%	70.59%	9.65
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	9.25%	Not Comparable
Use of Imaging Studies for Low Back Pain	80.84%	82.77%	79.30%	81.28%	1.98

Table 3.75—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results Anthem—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and

Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	49.25	46.66	48.40	45.58	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	221.60	221.41	242.89	226.88	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	35.19%	36.58%	32.67%	29.29%	-3.38
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	14.63%	Not Comparable
Use of Imaging Studies for Low Back Pain	78.42%	74.91%	74.49%	75.79%	1.30

Table 3.76—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results Anthem—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and

Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	58.42	56.54	56.82	48.71	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	267.79	271.12	306.23	301.91	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	29.79%	44.57%	52.75%	34.18%	-18.57
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	9.24%	Not Comparable
Use of Imaging Studies for Low Back Pain	75.68%	81.73%	78.47%	81.25%	2.78

Table 3.77—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results Anthem—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and

Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	50.58	49.89	48.93	44.71	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	287.61	267.76	290.54	288.79	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	**13.01%**	**10.95%**	25.19%	35.16%	9.97
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	14.67%	Not Comparable
Use of Imaging Studies for Low Back Pain	75.31%	80.45%	77.04%	82.03%	4.99

Table 3.78—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and

Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	50.01	49.10	48.42	46.80	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	327.81	310.92	291.24	277.03	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	**21.39%**	**17.85%**	**23.98%**	**23.05%**	-0.93
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	17.49%	Not Comparable
Use of Imaging Studies for Low Back Pain	74.19%	74.77%	75.41%	72.92%	-2.49

Table 3.79—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG

suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	52.86	52.53	53.56	52.01	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	230.38	231.95	230.73	236.69	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	33.67%	33.43%	34.63%	37.88%	3.25
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	9.97%	Not Comparable
Use of Imaging Studies for Low Back Pain	75.92%	73.39%	71.93%	73.25%	1.32

Table 3.80—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results Anthem—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and

Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	53.84	53.99	55.97	54.67	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	200.75	196.08	212.44	215.96	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	30.61%	40.92%	44.00%	46.42%	2.42
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	16.08%	Not Comparable
Use of Imaging Studies for Low Back Pain	77.44%	76.32%	74.13%	70.83%	-3.30

Table 3.81—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results Anthem—San Benito County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and

Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	46.51	48.82	50.01	48.56	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	260.79	239.61	246.19	238.46	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	37.50%	NA	48.08%	33.33%	-14.75
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	S	Not Comparable
Use of Imaging Studies for Low Back Pain	76.67%	75.28%	76.19%	67.82%	-8.37

Table 3.82—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results Anthem—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and

Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	47.95	46.65	45.46	47.19	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	230.13	230.95	243.22	245.52	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	54.84%	68.18%	61.40%	67.50%	6.10
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	15.70%	Not Comparable
Use of Imaging Studies for Low Back Pain	79.22%	85.16%	80.24%	79.67%	-0.57

Table 3.83—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results Anthem—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and

Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	38.27	37.73	40.47	41.30	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	207.56	186.88	190.99	204.03	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	30.19%	33.42%	36.92%	33.10%	-3.82
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	16.94%	Not Comparable
Use of Imaging Studies for Low Back Pain	80.05%	78.64%	81.25%	74.34%	-6.91

Table 3.84—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results Anthem—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and

Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	40.01	37.12	35.53	30.80	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	299.33	296.89	302.92	293.01	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	24.45%	30.16%	31.99%	28.11%	-3.88
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	13.09%	Not Comparable
Use of Imaging Studies for Low Back Pain	80.13%	75.63%	80.63%	77.59%	-3.04

Table 3.85 through Table 3.96 present findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.85—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Alameda County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	2	100.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	2	100.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.86—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Contra Costa County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	2	100.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	2	100.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.87—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Fresno County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.88—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Kings County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	2	50.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.89—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Madera County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	2	50.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.90—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	2	50.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	1	0.00%

Table 3.91—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.92—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Sacramento County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	2	50.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.93—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—San Benito County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.94—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—San Francisco County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	2	50.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.95—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Santa Clara County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.96—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Anthem—Tulare County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Assessment of Improvement Plans—Appropriate Treatment and Utilization

Based on reporting year 2018 performance measure results, DHCS required Anthem to submit an IP for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Region 1. The MCP conducted PDSA cycles to test whether conducting provider education, disseminating beneficiary materials about acute bronchitis, and using the Centers for Disease Control and Prevention's Symptom Relief Rx Pad during beneficiary encounters at a select clinic in Sutter County would improve the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure rate. Anthem reported that the providers expressed concern about receiving negative perception and care ratings from beneficiaries who were not prescribed antibiotics. The feedback from providers resulted in Anthem determining that the MCP needs to develop a more effective educational forum about acute bronchitis management to help beneficiaries understand why prescribing antibiotics for acute bronchitis is not clinically indicated.

The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure rate in Region 1 remained below the minimum performance level in reporting year 2019.

Performance Measure Findings—All Domains

Table 3.97 through Table 3.108 present a summary of Anthem's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.97 through Table 3.108:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.97—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Anthem—Alameda County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	19	10.53%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	3	33.33%
Reporting Year 2019 Rates Below Minimum Performance Levels	4	19	21.05%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	1	19	5.26%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	16	12.50%

Table 3.98—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Anthem—Contra Costa County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	19	10.53%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	2	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	5	19	26.32%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	1	19	5.26%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	3	17	17.65%

Table 3.99—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Anthem—Fresno County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	3	33.33%
Reporting Year 2019 Rates Below Minimum Performance Levels	4	19	21.05%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	2	19	10.53%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	16	12.50%

Table 3.100—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Anthem—Kings County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	19	5.26%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	19	15.79%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	3	33.33%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	2	19	10.53%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	16	0.00%

Table 3.101—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Anthem—Madera County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	4	19	21.05%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	2	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	1	19	5.26%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	17	0.00%

Table 3.102—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	19	15.79%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	5	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	7	19	36.84%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	3	19	15.79%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	14	14.29%

Table 3.103—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	4	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	5	19	26.32%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	2	19	10.53%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	15	6.67%

Table 3.104—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Anthem—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	19	10.53%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	4	19	21.05%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	4	25.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	4	19	21.05%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	2	19	10.53%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	15	6.67%

Table 3.105—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Anthem—San Benito County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	19	5.26%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	5	20.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	6	19	31.58%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	3	19	15.79%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	14	14.29%

Table 3.106—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Anthem—San Francisco County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	3	19	15.79%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	2	50.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	19	5.26%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	1	19	5.26%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	17	0.00%

Table 3.107—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Anthem—Santa Clara County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	19	15.79%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	1	19	5.26%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	18	11.11%

Table 3.108—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Anthem—Tulare County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	19	5.26%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	3	19	15.79%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	19	10.53%

Improvement Plan Requirements for 2019

Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, DHCS will require Anthem to continue conducting IPs for the following measures:

- *Asthma Medication Ratio* in Alameda, Fresno, Sacramento, and San Francisco counties
- *Breast Cancer Screening* in Contra Costa County, Fresno County, Kings County, Region 1, and Region 2
- *Childhood Immunization Status—Combination 3* in Region 2 and San Benito County
- *Comprehensive Diabetes Care—HbA1c Testing* in San Benito County

Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, DHCS will require Anthem to submit IPs or incorporate the measures into existing IPs for the following measures:

- *Asthma Medication Ratio* in Santa Clara County
- *Breast Cancer Screening* in Alameda County
- *Childhood Immunization Status—Combination 3* in Sacramento County
- *Comprehensive Diabetes Care—HbA1c Testing* in Alameda County, Contra Costa County, Region 1, Region 2, and Santa Clara County
- *Immunizations for Adolescents—Combination 2* in Region 1 and San Benito County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in San Benito County

Note that while the rates for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in Region 1 and *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure in Alameda County, Contra Costa County, Region 1, Region 2, and Santa Clara County were below the minimum performance levels in reporting year 2019, DHCS will not require Anthem to submit IPs for these two measures. This is due to DHCS not requiring MCPs to report rates for these measures for reporting year 2020.

Additionally, while in reporting year 2019 the rates were below the minimum performance levels for the following two measures, DHCS will not require Anthem to submit IPs for these measures due to the small range of variation between the high performance level and minimum performance level thresholds for each measure.

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors* or ARBs measure in Contra Costa County, Fresno County, Kings County, Madera County, Region 1, Region 2, Sacramento County, San Benito County, and Tulare County
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure in Contra Costa County, Fresno County, Madera County, Region 1, Sacramento County, San Benito County, and Tulare County

Seniors and Persons with Disabilities Performance Measure Results

Table 3.109 through Table 3.120 present the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.121 through Table 3.132 present the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.133 through Table 3.144 present the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.109—Multi-Year SPD Performance Measure Trend Table Anthem—Alameda County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.133 through Table 3.144.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	106.54	96.50	100.72	101.36	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	290.68	317.70	337.92	334.23	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.14%	88.95%	88.67%	90.54%	1.87
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.96%	87.31%	88.91%	90.51%	1.60
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	85.35%	89.06%	80.00%	72.84%	-7.16
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	85.32%	85.78%	89.81%	82.20%	-7.61

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	81.86%	80.20%	84.68%	80.28%	-4.40
*Plan All-Cause Readmissions***	—	—	—	22.38%	Not Comparable

Table 3.110—Multi-Year SPD Performance Measure Trend Table Anthem—Contra Costa County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	87.74	76.90	80.45	76.69	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	262.12	297.88	318.47	321.38	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.98%	88.57%	90.00%	86.12%	-3.88
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.24%	85.00%	90.70%	90.77%	0.07
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	92.86%	92.71%	89.13%	84.21%	-4.92
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	85.71%	88.06%	89.39%	90.24%	0.85

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	80.73%	81.51%	86.94%	78.31%	-8.63
*Plan All-Cause Readmissions***	—	—	—	9.80%	Not Comparable

Table 3.111—Multi-Year SPD Performance Measure Trend Table
Anthem—Fresno County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	74.39	68.55	74.62	71.93	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	365.85	380.04	404.40	367.54	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.90%	86.67%	88.41%	89.02%	0.61
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.58%	88.05%	88.89%	89.13%	0.24
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	81.30%	86.03%	80.97%	83.88%	2.91
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	87.93%	84.57%	86.07%	86.85%	0.78

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	81.81%	79.50%	81.88%	81.33%	-0.55
*Plan All-Cause Readmissions***	—	—	—	20.35%	Not Comparable

Table 3.112—Multi-Year SPD Performance Measure Trend Table Anthem—Kings County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 SPD rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	108.86	95.87	105.78	87.78	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	454.05	511.02	565.22	589.91	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.35%	84.24%	89.47%	85.79%	-3.68
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.11%	91.30%	85.26%	86.87%	1.61
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.61%	86.44%	93.44%	85.94%	-7.50

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	92.54%	93.59%	81.71%	88.10%	6.39
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	83.33%	78.63%	79.28%	82.86%	3.58
*Plan All-Cause Readmissions***	—	—	—	S	Not Comparable

Table 3.113—Multi-Year SPD Performance Measure Trend Table
Anthem—Madera County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	78.35	77.24	83.03	69.48	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	524.24	506.21	523.74	513.93	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.38%	86.61%	92.31%	88.68%	-3.63
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.48%	87.69%	97.01%	91.89%	-5.12
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	100.00%	83.33%	NA	87.50%	Not Comparable

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	93.55%	92.06%	94.83%	95.24%	0.41
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	80.68%	87.36%	83.91%	91.21%	7.30
*Plan All-Cause Readmissions***	—	—	—	21.65%	Not Comparable

Table 3.114—Multi-Year SPD Performance Measure Trend Table Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	100.99	101.15	91.63	82.82	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	566.18	574.37	526.46	490.36	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.24%	87.53%	88.61%	87.71%	-0.90
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.77%	87.94%	86.36%	85.06%	-1.30
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	93.86%	89.93%	90.68%	81.67%	-9.01
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	92.11%	92.77%	93.05%	96.36%	3.31
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	92.00%	87.30%	89.07%	87.92%	-1.15
*Plan All-Cause Readmissions***	—	—	—	24.25%	Not Comparable

Table 3.115—Multi-Year SPD Performance Measure Trend Table Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	91.71	90.22	90.05	84.68	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	416.86	437.37	436.87	443.06	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.32%	86.94%	87.93%	88.22%	0.29
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.80%	87.21%	89.20%	90.57%	1.37
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	85.82%	77.58%	83.43%	76.40%	-7.03
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	96.30%	89.73%	87.63%	82.33%	-5.30

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	94.92%	79.48%	80.73%	80.18%	-0.55
*Plan All-Cause Readmissions***	—	—	—	12.60%	Not Comparable

Table 3.116—Multi-Year SPD Performance Measure Trend Table Anthem—Sacramento County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	89.43	90.37	92.01	86.21	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	349.22	362.78	400.62	403.71	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.64%	87.44%	89.66%	88.47%	-1.19
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.17%	87.95%	88.58%	88.38%	-0.20
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	90.63%	NA	88.89%	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	80.81%	84.45%	82.06%	83.53%	1.47
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	85.96%	85.31%	85.07%	83.99%	-1.08

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	81.37%	83.12%	81.07%	82.53%	1.46
*Plan All-Cause Readmissions***	—	—	—	22.85%	Not Comparable

Table 3.117—Multi-Year SPD Performance Measure Trend Table
Anthem—San Benito County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	142.86	125.79	70.85	65.30	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	566.82	454.40	421.60	403.51	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	NA	NA	NA	NA	Not Comparable
Annual Monitoring for Patients on Persistent Medications—Diuretics	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA	NA	NA	NA	Not Comparable

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA	NA	NA	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	NA	Not Comparable

Table 3.118—Multi-Year SPD Performance Measure Trend Table
Anthem—San Francisco County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	99.79	92.19	90.94	98.22	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	364.70	368.70	402.87	413.44	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.57%	90.36%	86.93%	89.14%	2.21
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.66%	87.46%	88.46%	86.89%	-1.57
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	69.70%	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	77.78%	84.00%	83.67%	86.05%	2.38

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	86.84%	84.11%	88.12%	80.00%	-8.12
*Plan All-Cause Readmissions***	—	—	—	20.73%	Not Comparable

Table 3.119—Multi-Year SPD Performance Measure Trend Table Anthem—Santa Clara County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	61.69	57.50	60.67	61.43	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	326.21	332.38	326.26	364.84	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.35%	90.07%	88.77%	90.13%	1.36
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.70%	91.26%	92.36%	90.85%	-1.51
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	75.76%	74.71%	76.74%	80.00%	3.26
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	82.04%	77.51%	80.00%	74.29%	-5.71

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	77.13%	75.17%	80.82%	76.47%	-4.35
*Plan All-Cause Readmissions***	—	—	—	21.70%	Not Comparable

Table 3.120—Multi-Year SPD Performance Measure Trend Table Anthem—Tulare County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	81.03	77.86	75.53	66.31	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	519.48	548.38	548.61	522.27	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.81%	91.20%	90.09%	90.27%	0.18
Annual Monitoring for Patients on Persistent Medications—Diuretics	92.70%	89.22%	92.17%	89.27%	-2.90
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	92.16%	92.09%	92.61%	90.84%	-1.77
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	92.25%	93.42%	94.12%	93.66%	-0.46

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	90.32%	91.97%	91.40%	91.21%	-0.19
*Plan All-Cause Readmissions***	—	—	—	18.35%	Not Comparable

Table 3.121—Multi-Year Non-SPD Performance Measure Trend Table Anthem—Alameda County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	44.63	42.72	42.97	42.45	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	156.02	159.53	174.48	173.62	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.87%	85.02%	84.71%	85.76%	1.05
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.12%	84.32%	84.43%	84.07%	-0.36
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	88.53%	86.86%	87.23%	86.32%	-0.91
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	78.69%	77.82%	82.24%	78.35%	-3.89
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	84.53%	82.50%	85.86%	81.28%	-4.58

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	80.10%	77.12%	82.21%	80.04%	-2.17
*Plan All-Cause Readmissions***	—	—	—	13.47%	Not Comparable

Table 3.122—Multi-Year Non-SPD Performance Measure Trend Table Anthem—Contra Costa County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	45.85	42.40	41.99	40.76	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	159.08	158.94	182.96	192.07	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.01%	82.60%	83.00%	83.82%	0.82
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.74%	77.27%	85.78%	80.37%	-5.41
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	90.85%	89.29%	94.24%	92.44%	-1.80
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.55%	81.97%	89.88%	83.42%	-6.46
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	87.70%	85.70%	89.22%	86.48%	-2.74

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.20%	81.84%	86.23%	81.15%	-5.08
*Plan All-Cause Readmissions***	—	—	—	8.91%	Not Comparable

Table 3.123—Multi-Year Non-SPD Performance Measure Trend Table Anthem—Fresno County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	47.35	45.14	46.57	43.68	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	210.71	210.43	231.59	216.78	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.25%	85.56%	85.56%	83.93%	-1.63
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.87%	84.94%	85.45%	82.81%	-2.64
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	93.92%	92.81%	94.36%	92.92%	-1.44
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	84.82%	84.40%	84.84%	83.98%	-0.86
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.04%	84.71%	84.27%	83.92%	-0.35

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	82.34%	80.41%	80.11%	80.28%	0.17
*Plan All-Cause Readmissions***	—	—	—	11.84%	Not Comparable

Table 3.124—Multi-Year Non-SPD Performance Measure Trend Table Anthem—Kings County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	55.21	54.27	53.92	46.43	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	255.91	257.27	290.86	285.11	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.47%	86.65%	83.00%	85.30%	2.30
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.69%	83.66%	83.88%	87.01%	3.13
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.13%	91.51%	94.04%	93.82%	-0.22
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.35%	84.72%	86.82%	85.44%	-1.38
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	85.18%	85.95%	85.74%	87.42%	1.68

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.82%	86.14%	84.92%	85.94%	1.02
*Plan All-Cause Readmissions***	—	—	—	9.44%	Not Comparable

Table 3.125—Multi-Year Non-SPD Performance Measure Trend Table Anthem—Madera County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	49.19	48.60	47.38	43.55	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	275.80	256.45	279.94	278.25	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.55%	82.73%	77.94%	77.55%	-0.39
Annual Monitoring for Patients on Persistent Medications—Diuretics	76.04%	85.11%	81.33%	79.51%	-1.82
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	97.06%	97.39%	97.73%	96.26%	-1.47
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	93.01%	92.01%	91.01%	92.10%	1.09
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	92.58%	93.15%	92.14%	93.22%	1.08

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	89.60%	88.88%	89.11%	89.52%	0.41
*Plan All-Cause Readmissions***	—	—	—	11.33%	Not Comparable

Table 3.126—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	45.39	44.75	44.87	43.92	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	306.19	288.88	271.92	259.95	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.79%	85.28%	84.28%	83.86%	-0.42
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.73%	84.96%	83.80%	83.71%	-0.09
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	96.55%	96.12%	95.63%	95.75%	0.12
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	88.79%	88.31%	86.45%	84.74%	-1.71
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	88.55%	89.04%	88.46%	87.80%	-0.66

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	86.25%	86.28%	85.19%	84.71%	-0.48
*Plan All-Cause Readmissions***	—	—	—	13.15%	Not Comparable

Table 3.127—Multi-Year Non-SPD Performance Measure Trend Table Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	50.11	49.94	51.00	49.69	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	217.19	217.86	216.25	222.02	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.78%	81.95%	84.21%	82.84%	-1.37
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.05%	80.87%	84.07%	85.41%	1.34
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	92.35%	92.16%	92.13%	92.37%	0.24
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.51%	81.60%	81.71%	80.96%	-0.75
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	83.07%	82.94%	82.86%	83.34%	0.48

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	83.26%	81.74%	81.90%	81.86%	-0.04
*Plan All-Cause Readmissions***	—	—	—	8.85%	Not Comparable

Table 3.128—Multi-Year Non-SPD Performance Measure Trend Table Anthem—Sacramento County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	50.06	50.47	52.54	51.52	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	185.01	179.98	194.48	197.16	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.75%	83.40%	83.22%	83.67%	0.45
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.24%	83.66%	82.19%	81.92%	-0.27
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	91.19%	91.16%	91.44%	91.95%	0.51
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	81.29%	78.96%	79.16%	82.15%	2.99
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	84.22%	82.44%	82.24%	82.04%	-0.20

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	80.36%	79.05%	79.34%	80.17%	0.83
*Plan All-Cause Readmissions***	—	—	—	10.54%	Not Comparable

Table 3.129—Multi-Year Non-SPD Performance Measure Trend Table
Anthem—San Benito County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 non-SPD rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	46.02	48.29	49.83	48.38	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	259.25	238.13	244.63	236.69	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.00%	85.34%	82.68%	73.57%	-9.11
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.31%	85.07%	81.58%	76.81%	-4.77
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	92.50%	91.72%	94.06%	92.57%	-1.49
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	84.93%	83.41%	83.72%	81.98%	-1.74

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.05%	84.34%	84.62%	83.83%	-0.79
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	82.22%	78.55%	80.83%	80.61%	-0.22
*Plan All-Cause Readmissions***	—	—	—	S	Not Comparable

Table 3.130—Multi-Year Non-SPD Performance Measure Trend Table Anthem—San Francisco County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	36.13	37.08	36.02	36.53	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	199.46	202.01	210.12	210.45	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.92%	88.63%	85.45%	89.11%	3.66
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.55%	84.15%	89.02%	87.02%	-2.00
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.20%	93.79%	96.76%	99.39%	2.63
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	84.48%	85.45%	85.71%	83.87%	-1.84

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	90.55%	89.40%	88.30%	86.82%	-1.48
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.15%	87.62%	87.12%	86.63%	-0.49
*Plan All-Cause Readmissions***	—	—	—	7.89%	Not Comparable

Table 3.131—Multi-Year Non-SPD Performance Measure Trend Table Anthem—Santa Clara County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	36.18	36.14	38.82	39.55	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	196.98	175.18	179.94	190.02	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.83%	87.47%	88.04%	87.26%	-0.78
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.72%	86.47%	88.11%	88.05%	-0.06
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	91.40%	91.49%	92.03%	90.41%	-1.62
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	82.75%	82.36%	83.12%	84.49%	1.37

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.68%	86.13%	85.60%	85.99%	0.39
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.60%	81.02%	82.11%	83.01%	0.90
*Plan All-Cause Readmissions***	—	—	—	14.73%	Not Comparable

Table 3.132—Multi-Year Non-SPD Performance Measure Trend Table Anthem—Tulare County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	37.55	34.96	33.45	28.88	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	286.12	283.51	290.09	280.63	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.51%	86.92%	87.64%	84.51%	-3.13
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.47%	85.67%	85.27%	83.90%	-1.37
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	97.27%	96.59%	96.90%	97.06%	0.16
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	91.68%	90.58%	90.05%	89.65%	-0.40

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.81%	91.64%	91.46%	91.67%	0.21
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	90.71%	90.18%	89.95%	90.52%	0.57
*Plan All-Cause Readmissions***	—	—	—	10.98%	Not Comparable

Table 3.133—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem—Alameda County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	101.36	42.45	Not Tested	47.80
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	334.23	173.62	Not Tested	188.21
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.54%	85.76%	4.78	87.64%
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.51%	84.07%	6.44	86.74%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	86.32%	Not Comparable	86.41%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	72.84%	78.35%	-5.51	78.25%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	82.20%	81.28%	0.92	81.32%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	80.28%	80.04%	0.24	80.05%
*Plan All-Cause Readmissions***	22.38%	13.47%	8.91	17.54%

Table 3.134—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem—Contra Costa County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	76.69	40.76	Not Tested	43.58
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	321.38	192.07	Not Tested	202.22
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.12%	83.82%	2.30	84.64%
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.77%	80.37%	10.40	84.30%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	92.44%	Not Comparable	92.29%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	84.21%	83.42%	0.79	83.45%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	90.24%	86.48%	3.76	86.65%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	78.31%	81.15%	-2.84	80.96%
*Plan All-Cause Readmissions***	9.80%	8.91%	0.89	9.25%

Table 3.135—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem—Fresno County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	71.93	43.68	Not Tested	45.58
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	367.54	216.78	Not Tested	226.88
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.02%	83.93%	5.09	85.23%
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.13%	82.81%	6.32	84.50%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	92.92%	Not Comparable	92.98%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.88%	83.98%	-0.10	83.98%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.85%	83.92%	2.93	84.02%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	81.33%	80.28%	1.05	80.32%
*Plan All-Cause Readmissions***	20.35%	11.84%	8.51	14.63%

Table 3.136—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem—Kings County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2019 SPD or non-SPD rate is suppressed, HSAG also suppresses the SPD/non-SPD rate difference.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	87.78	46.43	Not Tested	48.71
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	589.91	285.11	Not Tested	301.91
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.79%	85.30%	0.49	85.43%
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.87%	87.01%	-0.14	86.98%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	93.82%	Not Comparable	93.89%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	85.94%	85.44%	0.50	85.45%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	88.10%	87.42%	0.68	87.45%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	82.86%	85.94%	-3.08	85.83%
*Plan All-Cause Readmissions***	S	9.44%	-0.80	9.24%

Table 3.137—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem—Madera County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	69.48	43.55	Not Tested	44.71
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	513.93	278.25	Not Tested	288.79
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.68%	77.55%	11.13	79.36%
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.89%	79.51%	12.38	82.39%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	96.26%	Not Comparable	96.29%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.50%	92.10%	-4.60	92.04%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	95.24%	93.22%	2.02	93.26%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	91.21%	89.52%	1.69	89.57%
*Plan All-Cause Readmissions***	21.65%	11.33%	10.32	14.67%

Table 3.138—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	82.82	43.92	Not Tested	46.80
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	490.36	259.95	Not Tested	277.03
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.71%	83.86%	3.85	84.87%
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.06%	83.71%	1.35	84.13%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	95.75%	Not Comparable	95.80%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	81.67%	84.74%	-3.07	84.68%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	96.36%	87.80%	8.56	88.04%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.92%	84.71%	3.21	84.82%
*Plan All-Cause Readmissions***	24.25%	13.15%	11.10	17.49%

Table 3.139—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	84.68	49.69	Not Tested	52.01
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	443.06	222.02	Not Tested	236.69
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.22%	82.84%	5.38	84.39%
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.57%	85.41%	5.16	86.95%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	92.37%	Not Comparable	92.44%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	76.40%	80.96%	-4.56	80.86%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	82.33%	83.34%	-1.01	83.31%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	80.18%	81.86%	-1.68	81.81%
*Plan All-Cause Readmissions***	12.60%	8.85%	3.75	9.97%

Table 3.140—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem—Sacramento County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	86.21	51.52	Not Tested	54.67
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	403.71	197.16	Not Tested	215.96
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.47%	83.67%	4.80	85.43%
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.38%	81.92%	6.46	84.49%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	91.95%	Not Comparable	91.98%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.53%	82.15%	1.38	82.18%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	83.99%	82.04%	1.95	82.12%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	82.53%	80.17%	2.36	80.30%
*Plan All-Cause Readmissions***	22.85%	10.54%	12.31	16.08%

Table 3.141—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem—San Benito County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2019 SPD or non-SPD rate is suppressed, HSAG also suppresses the SPD/non-SPD rate difference.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	65.30	48.38	Not Tested	48.56
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	403.51	236.69	Not Tested	238.46
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	NA	73.57%	Not Comparable	72.11%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Annual Monitoring for Patients on Persistent Medications—Diuretics	NA	76.81%	Not Comparable	74.32%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	92.57%	Not Comparable	92.57%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	NA	81.98%	Not Comparable	82.20%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA	83.83%	Not Comparable	83.93%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA	80.61%	Not Comparable	80.71%
*Plan All-Cause Readmissions***	NA	S	Not Comparable	S

Table 3.142—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem—San Francisco County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	98.22	36.53	Not Tested	47.19
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	413.44	210.45	Not Tested	245.52
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.14%	89.11%	0.03	89.12%
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.89%	87.02%	-0.13	86.96%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	99.39%	Not Comparable	99.39%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	NA	83.87%	Not Comparable	83.97%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.05%	86.82%	-0.77	86.78%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	80.00%	86.63%	-6.63	86.18%
*Plan All-Cause Readmissions***	20.73%	7.89%	12.84	15.70%

Table 3.143—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem—Santa Clara County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	61.43	39.55	Not Tested	41.30
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	364.84	190.02	Not Tested	204.03
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.13%	87.26%	2.87	88.20%
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.85%	88.05%	2.80	88.96%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	90.41%	Not Comparable	90.45%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	80.00%	84.49%	-4.49	84.42%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	74.29%	85.99%	-11.70	85.64%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	76.47%	83.01%	-6.54	82.75%
*Plan All-Cause Readmissions***	21.70%	14.73%	6.97	16.94%

Table 3.144—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem—Tulare County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	66.31	28.88	Not Tested	30.80
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	522.27	280.63	Not Tested	293.01
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.27%	84.51%	5.76	85.80%
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.27%	83.90%	5.37	85.34%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	97.06%	Not Comparable	96.97%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	90.84%	89.65%	1.19	89.68%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	93.66%	91.67%	1.99	91.72%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	91.21%	90.52%	0.69	90.54%
*Plan All-Cause Readmissions***	18.35%	10.98%	7.37	13.09%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that Anthem stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 SPD rates were significantly worse than the reporting year 2018 SPD rates for the following measures:
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Region 1
  - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Alameda County

- *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Contra Costa County

- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* and *12–19 Years* measures in Sacramento County.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly worse than the reporting year 2018 non-SPD rates for the following measures:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Tulare County
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Alameda County, Contra Costa County, and Region 1
  - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* in Alameda and Contra Costa counties
- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
    - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Alameda County, Fresno County, Madera County, Region 1, Region 2, Sacramento County, and Tulare County
    - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Alameda County, Contra Costa County, Fresno County, Madera County, Region 2, Sacramento County, and Tulare County
    - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Region 1
    - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Sacramento County
  - The reporting year 2019 SPD rates were significantly worse than the reporting year 2019 non-SPD rates for the following measures:
    - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* in Santa Clara County. Note that the significant differences in rates for these measures may be attributed to beneficiaries in these age groups in the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from PCPs.
    - *Plan All-Cause Readmissions* in Alameda County, Fresno County, Madera County, Region 1, Region 2, Sacramento County, San Francisco County, Santa Clara County, and Tulare County. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that Anthem followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for Anthem across all domains and reporting units:

- Sixteen of 228 rates for which MCPs were held accountable to meet the minimum performance levels in reporting year 2019 (7 percent) were above the high performance levels in reporting year 2019, with the following measures having rates above the high performance levels for the last three or more consecutive years:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Alameda, Contra Costa, Sacramento, and San Francisco counties
  - *Use of Imaging Studies for Low Back Pain* in Alameda, Contra Costa, and Kings counties
  - Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures in Madera County
- Seventeen of 228 rates for which HSAG made comparisons between reporting year 2018 and reporting year 2019 (7 percent) improved significantly from reporting year 2018 to reporting year 2019.
- For rates for which MCPs were held accountable to meet the minimum performance levels in reporting year 2018 and reporting year 2019, six of the 34 rates that were below the minimum performance levels in reporting year 2018 (18 percent) improved from below the minimum performance levels in reporting year 2018 to above the minimum performance levels in reporting year 2019. For the following measures, the rates improved to above the minimum performance levels in reporting year 2019:
  - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Kings County
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in San Benito County
  - *Comprehensive Diabetes Care—HbA1c Testing* in Sacramento County
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Fresno and San Francisco counties
  - *Prenatal and Postpartum Care—Postpartum Care* in Alameda County

Opportunities for Improvement—Performance Measures

Across all domains and reporting units, 45 of 228 rates for which MCPs were held accountable to meet the minimum performance levels in reporting year 2019 (20 percent) were below the minimum performance levels in reporting year 2019. Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, Anthem has the greatest opportunities for improvement related to the following measures with rates below the minimum performance levels in reporting year 2019:

- *Asthma Medication Ratio* in Alameda, Fresno, Sacramento, San Francisco, and Santa Clara counties
- *Breast Cancer Screening* in Alameda County, Contra Costa County, Fresno County, Kings County, Region 1, and Region 2
- *Childhood Immunization Status—Combination 3* in Region 2, Sacramento County, and San Benito County
- *Comprehensive Diabetes Care—HbA1c Testing* in Alameda County, Contra Costa County, Region 1, Region 2, San Benito County, and Santa Clara County
- *Immunizations for Adolescents—Combination 2* in Region 1 and San Benito County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in San Benito County

Additionally, to prevent the rates from moving to below the minimum performance levels, Anthem has opportunities for improvement related to the following measures with rates that declined significantly from reporting year 2018 to reporting year 2019:

- *Childhood Immunization Status—Combination 3* in Tulare County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Alameda, Kings, and Tulare counties

Anthem should determine whether current improvement strategies related to the measures listed previously with declining rates or rates below the minimum performance levels need to be modified or expanded to improve the MCP's performance.

In addition to the measures listed previously for which Anthem has opportunities for improvement, note the following:

- The rates for the following measures were below the minimum performance levels in reporting year 2019:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Region 1
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Alameda County, Contra Costa County, Region 1, Region 2, and Santa Clara County
- The rates for the following measures declined significantly from reporting year 2018 to reporting year 2019:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Kings County

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Madera County
- *Use of Imaging Studies for Low Back Pain* in Sacramento and Santa Clara counties

Note that HSAG makes no formal recommendations for these four measures because DHCS will not require MCPs to report the measures to DHCS in reporting year 2020. DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCP's quality improvement actions related to the measures.

Anthem also has opportunities for improvement related to the following two measures with rates below the minimum performance levels in reporting year 2019:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure rates in Contra Costa County, Fresno County, Kings County, Madera County, Region 1, Region 2, Sacramento County, San Benito County, and Tulare County
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Contra Costa County, Fresno County, Madera County, Region 1, Sacramento County, San Benito County, and Tulare County

While Anthem has opportunities for improvement related to these two measures, HSAG makes no formal recommendations to the MCP related to these measures due to the small range of variation between the high performance level and minimum performance level thresholds for each measure.

DHCS and HSAG expect that Anthem will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCP will conduct improvement activities, as applicable, related to the six measures for which HSAG provides no formal recommendations.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Anthem's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Anthem report rates for three HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for reporting years 2016 through 2019. The reporting year is the year in which the MLTSSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between reporting year 2018 and reporting year 2019. Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of those changes.

Table 4.1—Multi-Year MLTSSP Performance Measure Results
Anthem—Santa Clara County

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	43.04	63.09	73.72	65.68	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	282.89	480.17	545.27	553.18	Not Tested
Medication Reconciliation Post-Discharge	31.71%	37.84%	41.04%	45.45%	4.41

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure showed no statistically significant change from reporting year 2018 to reporting year 2019.

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, Anthem conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required Anthem to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, Anthem identified asthma medication ratio among the African-American population as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.1—Anthem *Asthma Medication Ratio* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of controller medication refills among a cohort of 67 non-compliant African Americans 5 to 64 years of age residing in Alameda County who have Provider Network B[6] as their primary care provider	13.6%	16.4%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Asthma Medication Ratio* Disparity PIP that the MCP resubmitted due to a change in study cohort size. Upon initial review of the modules, HSAG determined that Anthem met all required validation criteria for Module 1; however, HSAG identified opportunities for improvement related to Module 2. After receiving technical assistance from HSAG, Anthem incorporated HSAG's feedback into Module 2, and HSAG determined that the MCP met all validation criteria for Module 2.

[6] Provider network name removed for confidentiality.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Asthma Medication Ratio* Disparity PIP, HSAG reviewed and provided feedback to Anthem on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Anthem that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.2 presents a description of the intervention that Anthem tested for its *Asthma Medication Ratio* Disparity PIP. The table also indicates the failure modes that the intervention addressed.

Table 5.2—Anthem *Asthma Medication Ratio* Disparity PIP Intervention Testing

Intervention	Failure Modes Addressed
Providing one-on-one telephonic health education counseling sessions to promote beneficiaries to take proactive roles in controlling their asthma.	♦ Beneficiary not provided with information about the importance of asthma self-management. ♦ Beneficiary not interested in understanding the information provided. ♦ Clinic staff does not understand how to counsel on asthma self-management.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Anthem and conducted technical assistance calls with the MCP staff members to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although Anthem completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Anthem's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required Anthem to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, Anthem selected postpartum care as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.3—Anthem *Postpartum Care* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of postpartum visits among women who reside in Kings County	40.12%	55.47%

Table 5.4 presents a description of the intervention that Anthem tested for its *Postpartum Care* PIP. The table also indicates the failure modes that the intervention addressed.

Table 5.4—Anthem *Postpartum Care* PIP Intervention Testing

Intervention	Failure Modes Addressed
Counseling and providing education to beneficiaries during the prenatal period that emphasizes the importance of postpartum care	♦ Provider does not reinforce postpartum exam education. ♦ Women are not interested in understanding the education provided. ♦ Current education materials are not suitable.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Anthem to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although Anthem completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Anthem's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, Anthem submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on Anthem's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

7. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

8. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with Anthem, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

9. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 9.1 provides EQR recommendations from Anthem's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 9.1 to preserve the accuracy of Anthem's self-reported actions.

Table 9.1—Anthem's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to Anthem	Self-Reported Actions Taken by Anthem during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP fully resolves all deficiencies from the November 2017 A&I Medical Audit.	Anthem continues to work with DHCS in closing all 2017 A&I Medical Audit deficiencies.
2. To build on improvements already achieved, identify which strategies contributed to performance measure improvement from reporting year 2019 to reporting year 2018 and expand these successful strategies within the MCP and new provider sites, as applicable. The MCP should prioritize efforts on measures within the Preventive Screening and Women's Health and Care for Chronic Conditions domains.	Reporting year 2018 (measurement year 2017) HEDIS results showed that Anthem improved in all measures included in the Preventive Screening and Women's Health and the Care for Chronic Conditions domains. Anthem implemented a clinic days strategy that contributed to the performance measure improvements. Clinic days at provider offices were scheduled to not only get the members the care they needed but to bring awareness and education and to engage the participating provider offices to continue the work beyond just the clinic days. Anthem member outreach staff contacted members who were in need of services, and appointments were scheduled. Services that were conducted at the clinic days included lab tests for the *Annual Monitoring for Patients on Persistent Medications*,

2017–18 External Quality Review Recommendations Directed to Anthem	Self-Reported Actions Taken by Anthem during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	Comprehensive Diabetes Care—HbA1c, and *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measures. Blood pressure was also checked at the time of the visit. Women's health clinic days were scheduled to target members in need of cervical and breast cancer screenings. Another strategy that Anthem used was a mobile clinic unit (MedXM). Members who were targeted for this intervention included homebound members and members not able to get to their PCP for numerous reasons. MedXM conducted lab draws for *Comprehensive Diabetes Care* and *Annual Monitoring for Patients on Persistent Medications* measures, eye exams for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure, and blood pressure screenings. This intervention was an effort to meet members "where they were." A booth was even set up at local farmers markets in Fresno and San Benito counties to make it easy for the member to attend. Member outreach calls targeting members who have not been in for care continues to be an ongoing intervention. Members are contacted to encourage them to schedule a visit with their PCP. Member outreach staff have the ability to assist members with scheduling a PCP visit and also assisting with PCP reassignment. *Comprehensive Diabetes Care* and *Childhood Immunization Status* measures were the primary focus. Provider education is another ongoing intervention. Providers are visited by experienced MCP staff to discuss best

2017–18 External Quality Review Recommendations Directed to Anthem	Self-Reported Actions Taken by Anthem during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	practices for member engagement, coding guidelines, and member gap-in-care reports. All measures are included in this intervention. An Asthma Education Toolkit was also created to assist providers with their asthma patients. The toolkit was disseminated at provider visits in all counties. Member outreach calls to newly pregnant women is another intervention that has assisted in improving *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rates. The outreach call encourages women to go in for their prenatal visits in a timely manner. After the women deliver, they are contacted to schedule their postpartum care visit.
3. Continue monitoring adapted interventions and outcomes to facilitate improvement beyond the life of the 2015–17 *Controlling Blood Pressure* and *Comprehensive Diabetes Care* PIPs	NCQA updated the technical specifications allowing blood pressure coding to be used in administrative data for the *Controlling High Blood Pressure* and *Comprehensive Diabetes Care—Blood Pressure Control (140/90 mm Hg)* measures. Education about blood pressure coding was developed and delivered at provider offices across the State, and providers were encouraged to use the coding. A PDSA for HbA1c in San Benito County was initiated in 2018 to increase HbA1c testing rates through the use of member clinic days.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Anthem's self-reported actions in Table 9.1 and determined that Anthem adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. The following interventions described by the MCP may have contributed to the improvement that HSAG noted in Section 3 of this report ("Managed Care Health Plan Performance Measures") under the Strengths—Performance Measures heading:

- Clinic days that included beneficiary outreach and education
- Mobile clinic unit for beneficiaries who were homebound or unable to travel to their PCPs
- Outreach calls to newly pregnant beneficiaries, beneficiaries who had recently delivered a baby, and beneficiaries who had not been seen for needed health care services
- Provider education
- Dissemination of a provider Asthma Education Toolkit

2018–19 Recommendations

Based on the overall assessment of Anthem's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to ensure that the MCP fully resolves all findings from the 2017 and 2018 A&I Medical Audits.
- Determine whether current improvement strategies related to the following measures with declining rates or rates below the minimum performance levels in reporting year 2019 need to be modified or expanded to improve the MCP's performance:
  - *Asthma Medication Ratio* in Alameda, Fresno, Sacramento, San Francisco, and Santa Clara counties
  - *Breast Cancer Screening* in Alameda County, Contra Costa County, Fresno County, Kings County, Region 1, and Region 2
  - *Childhood Immunization Status—Combination 3* in Region 2, Sacramento County, San Benito County, and Tulare County
  - *Comprehensive Diabetes Care—HbA1c Testing* in Alameda County, Contra Costa County, Region 1, Region 2, San Benito County, and Santa Clara County
  - *Immunizations for Adolescents—Combination 2* in Region 1 and San Benito County
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Alameda, Kings, San Benito, and Tulare counties

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix F:
Performance Evaluation Report
Blue Shield of California Promise Health Plan
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Blue Shield of California Promise Health Plan (prior to January 1, 2019, known as Care1st Health Plan and referred to in this report as "Blue Shield Promise" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in Blue Shield Promise's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Blue Shield Promise is a full-scope MCP delivering services to beneficiaries under a Geographic Managed Care (GMC) model. The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

In addition to Blue Shield Promise, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Community Health Group Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser SoCal
- Molina Healthcare of California Partner Plan, Inc.
- UnitedHealthcare Community Plan

Blue Shield Promise became operational in San Diego County to provide MCMC services effective February 2006. As of June 2019, Blue Shield Promise had 80,839 beneficiaries.[1] This represents 12 percent of the beneficiaries enrolled in San Diego County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

DHCS Audits & Investigations Division (A&I) conducted on-site Medical and State Supported Services Audits of Blue Shield Promise from January 22, 2019, through January 25, 2019, covering the review period of January 1, 2018, through December 31, 2018. At the time that this MCP-specific evaluation report was produced, the audit reports were pending. HSAG will include the results of the January 2019 audits in Blue Shield Promise's 2019–20 MCP-specific evaluation report.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for Blue Shield of California Promise Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that Blue Shield Promise followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for Blue Shield Promise's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.
- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Blue Shield Promise—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**66.18%**	70.07%	66.18%	67.40%	1.22
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**82.07%**	**81.38%**	**81.29%**	**85.88%**	4.59

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**73.77%**	**72.10%**	**71.27%**	**71.77%**	0.50
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**77.72%**	**74.91%**	**76.21%**	**76.02%**	-0.19
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**73.59%**	**68.67%**	**70.67%**	**70.90%**	0.23
Immunizations for Adolescents—Combination 2	—	18.68%	28.22%	37.23%	9.01
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	76.64%	79.23%	82.49%	85.25%	2.76

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	66.67%	69.40%	76.84%	83.61%	6.77
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**61.99%**	**63.66%**	67.71%	**61.75%**	-5.96

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Blue Shield Promise—San Diego County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	5	40.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	5	40.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	5	20.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	5	20.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Blue Shield Promise—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	54.02%	**51.35%**	54.00%	2.65
Cervical Cancer Screening	**47.45%**	58.39%	**49.63%**	57.95%	8.32
Prenatal and Postpartum Care—Postpartum Care	64.72%	69.21%	67.80%	70.22%	2.42
Prenatal and Postpartum Care—Timeliness of Prenatal Care	81.51%	78.42%	82.49%	81.97%	-0.52

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Blue Shield Promise—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Assessment of Improvement Plans—Preventive Screening and Women's Health

Based on reporting year 2018 performance measure results, DHCS required Blue Shield Promise to submit IPs for the following measures within the Preventive Screening and Women's Health domain:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*

Breast Cancer Screening

Blue Shield Promise conducted two PDSA cycles to test whether conducting provider education and beneficiary telephone outreach would improve mammogram screening rates. Blue Shield Promise reported that the MCP was successful in establishing a working relationship with the quality improvement leads at the clinics. Additionally, Blue Shield Promise indicated identifying that using a standardized form with a running account of all outreach conducted for each beneficiary created opportunities for improving the MCP's outreach report.

The *Breast Cancer Screening* measure rate improved significantly from reporting year 2018 to reporting year 2019, resulting in the rate moving to above the minimum performance level in reporting year 2019.

Cervical Cancer Screening

Blue Shield Promise conducted two PDSA cycles to test whether conducting provider in-service training and having the providers conduct beneficiary telephone outreach using gap-in-care lists would result in improved beneficiary cervical cancer screening compliance. The MCP indicated that clinics reported that beneficiaries who were seen prior to the clinics receiving the gap-in-care lists refused to schedule another exam for the cervical cancer screening and instead opted to wait until their next visit.

The *Cervical Cancer Screening* measure rate improved significantly from reporting year 2018 to reporting year 2019, resulting in the rate moving to above the minimum performance level in reporting year 2019.

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending

for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Blue Shield Promise—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.41%	91.52%	90.28%	91.83%	1.55
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.75%	89.43%	89.92%	91.93%	2.01
*Asthma Medication Ratio^*	—	**21.84%**	**28.24%**	**32.38%**	4.14
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	60.10%	69.10%	72.75%	69.10%	-3.65
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**46.47%**	56.69%	55.72%	54.01%	-1.71
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	50.61%	53.53%	54.01%	51.58%	-2.43
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	40.63%	35.77%	34.79%	39.66%	4.87
*Comprehensive Diabetes Care—HbA1c Testing^*	83.45%	89.29%	86.86%	88.08%	1.22

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	89.78%	91.48%	92.46%	89.05%	-3.41
Controlling High Blood Pressure	—	—	—	64.96%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Blue Shield Promise—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	9	11.11%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	8	0.00%

Assessment of Improvement Plans—Care for Chronic Conditions

Based on reporting year 2018 performance measure results, DHCS required Blue Shield Promise to submit an IP for the *Asthma Medication Ratio* measure. Blue Shield Promise conducted two PDSA cycles to improve the MCP's performance.

For both PDSA cycles, the MCP tested whether conducting provider in-service training and having the providers conduct beneficiary telephone outreach would improve the *Asthma Medication Ratio* measure rate. The MCP reported learning that using a pharmacy utilization report can be instrumental in keeping providers informed of their patients' compliance with asthma medications.

The *Asthma Medication Ratio* measure rate remained below the minimum performance level in reporting year 2019.

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Blue Shield Promise—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	46.25	42.99	42.79	41.92	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	341.22	350.69	269.38	438.72	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	25.14%	30.83%	40.36%	38.62%	-1.74
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	17.07%	Not Comparable
Use of Imaging Studies for Low Back Pain	**66.59%**	**64.19%**	**62.56%**	**66.77%**	4.21

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Blue Shield Promise—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	2	50.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	1	0.00%

Assessment of Improvement Plans—Appropriate Treatment and Utilization

To address Blue Shield Promise's performance below the minimum performance level for multiple years for the *Use of Imaging Studies for Low Back Pain* measure, DHCS required Blue Shield Promise to submit a Pilot Quality Improvement Strategy Summary/Progress report which described the quality improvement strategies that the MCP implemented to improve its performance on the measure. The MCP indicated that it provided on-site education to providers with high rates for prescribing imaging studies for uncomplicated low back pain and found the providers difficult to engage in the process due to the providers having differing opinions about the criteria for prescribing imaging studies. The MCP noted that further education is needed.

The *Use of Imaging Studies for Low Back Pain* measure rate remained below the minimum performance level in reporting year 2019.

Performance Measure Findings—All Domains

Table 3.9 presents a summary of Blue Shield Promise's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Blue Shield Promise—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	19	10.53%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	5	19	26.32%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	3	33.33%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	19	15.79%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	1	19	5.26%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	16	6.25%

Improvement Plan Requirements for 2019

Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, DHCS will require Blue Shield Promise to:

- Continue submitting an IP for the *Asthma Medication Ratio* measure.
- Submit an IP for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure.

Note that while the *Use of Imaging Studies for Low Back Pain* measure rate was below the minimum performance level in reporting year 2019, DHCS will not require Blue Shield Promise to submit an IP for this measure. This is due to DHCS not requiring MCPs to report rates for the *Use of Imaging Studies for Low Back Pain* measure for reporting year 2020.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table
Blue Shield Promise—San Diego County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.12.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	90.10	84.98	86.05	71.79	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	587.62	653.93	510.33	922.21	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.55%	93.96%	92.41%	92.04%	-0.37
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.68%	93.82%	93.12%	93.24%	0.12

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners— 12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners— 25 Months–6 Years	68.87%	72.16%	60.68%	68.52%	7.84
Children and Adolescents' Access to Primary Care Practitioners— 7–11 Years	59.70%	70.68%	69.23%	71.92%	2.69
Children and Adolescents' Access to Primary Care Practitioners— 12–19 Years	55.83%	58.46%	58.64%	60.85%	2.21
*Plan All-Cause Readmissions***	—	—	—	23.14%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
Blue Shield Promise—San Diego County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	42.14	39.68	39.37	38.61	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	318.11	326.81	250.34	385.05	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.21%	90.70%	89.50%	91.69%	2.19
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.53%	87.83%	88.67%	90.99%	2.32
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	82.06%	81.47%	81.63%	86.03%	4.40
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	73.89%	72.10%	71.55%	71.85%	0.30
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	78.58%	75.08%	76.49%	76.19%	-0.30
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	74.69%	69.15%	71.22%	71.35%	0.13
*Plan All-Cause Readmissions***	—	—	—	14.04%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Blue Shield Promise—San Diego County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	71.79	38.61	Not Tested	41.92
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	922.21	385.05	Not Tested	438.72
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	92.04%	91.69%	0.35	91.83%
Annual Monitoring for Patients on Persistent Medications—Diuretics	93.24%	90.99%	2.25	91.93%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	86.03%	Not Comparable	85.88%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	68.52%	71.85%	-3.33	71.77%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	71.92%	76.19%	-4.27	76.02%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	60.85%	71.35%	-10.50	70.90%
*Plan All-Cause Readmissions***	23.14%	14.04%	9.10	17.07%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that Blue Shield Promise stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, Blue Shield Promise had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the following measures:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
  - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates, the reporting year 2019 SPD rates were significantly worse than the reporting year 2019 non-SPD rates for the following measures:
  - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*. The significant difference in rates for this measure may be attributed to beneficiaries in this age group in the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from primary care providers (PCPs).
  - *Plan All-Cause Readmissions*. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that Blue Shield Promise followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for Blue Shield Promise:

- The rates for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures were above the high performance levels.
- The rates for the following five of 19 measures (26 percent) improved significantly from reporting year 2018 to reporting year 2019:
  - Both *Annual Monitoring for Patients on Persistent Medications* measures
  - *Breast Cancer Screening*, resulting in the rate moving from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019
  - *Immunizations for Adolescents—Combination 2*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total*

Opportunities for Improvement—Performance Measures

Based on reporting year 2019 performance measure results, Blue Shield Promise has the following opportunities for improvement:

- To address the MCP's continued performance below the minimum performance level for the *Asthma Medication Ratio* measure, the MCP has the opportunity to assess whether current improvement strategies need to be changed or expanded to ensure that beneficiaries ages 5 to 64 who are identified as having persistent asthma have a ratio of controller medications to total asthma medications of 0.50 or greater.
- To improve the MCP's performance to above the minimum performance level for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, the MCP has the opportunity to determine the factors preventing beneficiaries ages 3 to 6 from being seen for one or more well-child visits with a PCP during the measurement year, and identify strategies to address the factors.

Note that the *Use of Imaging Studies for Low Back Pain* measure rate was below the minimum performance level in reporting year 2019. While the MCP has opportunities for improvement related to this measure, HSAG makes no formal recommendations to the MCP because DHCS will not require MCPs to report the measure to DHCS in reporting year 2020, and DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCP's quality improvement actions related to this measure. DHCS and HSAG expect that the MCP will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCP will conduct improvement activities, as applicable, related to this measure.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Blue Shield Promise's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Blue Shield Promise report rates for three HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for reporting years 2016 through 2019. The reporting year is the year in which the MLTSSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between reporting year 2018 and reporting year 2019. Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of those changes.

Table 4.1—Multi-Year MLTSSP Performance Measure Results
Blue Shield Promise—San Diego County

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	70.17	98.21	90.88	94.14	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	756.33	1,061.99	872.43	1,444.00	Not Tested
Medication Reconciliation Post-Discharge	22.49%	29.50%	30.50%	35.78%	5.28

Managed Long-Term Services and Supports Plan Performance Measure Findings

The *Medication Reconciliation Post-Discharge* measure rate showed no statistically significant change from reporting year 2018 to reporting year 2019.

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, Blue Shield Promise conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required Blue Shield Promise to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, Blue Shield Promise identified immunizations among non-Hispanic children as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.1—Blue Shield Promise *Childhood Immunization Status—Combination 3* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of non-Hispanic members 2 years of age residing in San Diego County who receive appropriate immunizations.	54.9%	74.0%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated modules 1 thorough 3 for the MCP's *Childhood Immunization Status—Combination 3* Disparity PIP. Upon initial review of the modules, HSAG determined that Blue Shield Promise met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Supporting the topic selection with the MCP's data.
- Including all required components of the:
  - SMART Aim developed based on literature review, data, and/or experience.
  - SMART Aim measure.
  - SMART Aim data collection methodology.
  - Run/control chart.
- Aligning accurately the Global Aim, SMART Aim, key drivers, and potential interventions.
- Capturing all required data elements in the data collection tool.

- Including team members responsible for completing the process mapping and FMEA.
- Including a step-by-step flow of the overall process in the process map.
- Supporting the sub-processes selection for the FMEA table.
- Including all required components of the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, Blue Shield Promise incorporated HSAG's feedback into modules 1 through 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for modules 1 through 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 3* Disparity PIP, HSAG reviewed and provided feedback to Blue Shield Promise on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Blue Shield Promise that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.2 presents a description of the intervention that Blue Shield Promise tested for its *Childhood Immunization Status—Combination 3* Disparity PIP. The table also indicates the failure modes that the intervention addressed.

Table 5.2—Blue Shield Promise *Childhood Immunization Status—Combination 3* Disparity PIP Intervention Testing

Intervention	Failure Modes Addressed
Conduct a text message campaign to send a standardized and approved text message, translated into 22 languages, to parents/guardians of children eligible for childhood immunizations.	♦ Parents/guardians do not return provider offices' calls even if voice messages are left. ♦ Parents/guardians may forget the appointments. ♦ Parents/guardians may realize the appointment dates are inconvenient.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Blue Shield Promise to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although Blue Shield Promise completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG

includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Blue Shield Promise's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required Blue Shield Promise to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. However, based on Blue Shield Promise demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. Blue Shield Promise selected well-child visits among beneficiaries ages 3 to 6 as its 2017–19 DHCS-priority PIP topic based on its MCP-specific data.

Table 5.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.3—Blue Shield Promise *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of well-care visits for children ages 3 to 6 years at Health Center A[6]	62.05%	68.30%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 1 through 3 for the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. Upon initial review of the modules, HSAG determined that Blue Shield Promise met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Supporting the topic selection with the MCP's data.
- Including all required components of the following:
  - SMART Aim, developed based on literature review, data, and/or experience.
  - SMART Aim measure.
  - SMART Aim data collection methodology.
  - Run/control chart.
- Aligning accurately the Global Aim, SMART Aim, key drivers, and potential interventions.
- Capturing all required data elements in the data collection tool.

[6] Health Center name removed for confidentiality.

- Including team members responsible for completing the process mapping and FMEA.
- Including a step-by-step flow of the overall process in the process map.
- Supporting the sub-processes selection for the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, Blue Shield Promise incorporated HSAG's feedback into modules 1 through 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for modules 1 through 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP, HSAG reviewed and provided feedback to Blue Shield Promise on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Blue Shield Promise that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.4 presents a description of the intervention that Blue Shield Promise tested for its *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. The table also indicates the failure modes that the intervention addressed.

Table 5.4—Blue Shield Promise *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP Intervention Testing

Intervention	Failure Modes Addressed
Conduct a text message campaign to send a standardized and approved text message, translated into 22 languages, to parents/guardians of children eligible for well-child care visits.	♦ Not all beneficiaries are successfully contacted to remind them of the well-child care visits. ♦ Parents/guardians do not return provider offices' calls even if voice messages are left. ♦ Parents/guardians do not show up at the appointments.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Blue Shield Promise to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although Blue Shield Promise completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG

includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Blue Shield Promise's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, Blue Shield Promise submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on Blue Shield Promise's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

7. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

8. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with Blue Shield Promise, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

9. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 9.1 provides EQR recommendations from Blue Shield Promise's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 9.1 to preserve the accuracy of Blue Shield Promise's self-reported actions.

Table 9.1—Blue Shield Promise's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Identify the causes for the MCP's performance below the minimum performance levels for the following measures, and identify strategies to improve the MCP's performance to above the minimum performance levels: a. *Asthma Mediation Ratio* b. *Breast Cancer Screening* c. *Cervical Cancer Screening*	As you can see in the chart below, Blue Shield Promise made improvements on all of the measures that fell below the minimum performance levels. The quality improvement team worked most of Quarter 1 and Quarter 2 2019 to gain the same data related to the *Asthma Medication Ratio* measure after the change of our pharmacy benefit manager on January 1, 2019. There may have been data delays at the beginning of 2019 that contributed to our rates. The *Breast Cancer Screening* measure rate improved over the prior year. We have recently launched improved provider incentives for this measure as well as member incentives. We are hopeful some of our member outreach will also help make improvements for measurement year 2019.

<table>
<tr><th>2017–18 External Quality Review Recommendations Directed to Blue Shield Promise</th><th>Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations</th></tr>
<tr><td></td><td>The Cervical Cancer Screening measure rate had a much larger improvement over the prior year. We will continue our interventions and hope for continued improvements. However, we are hoping that the NCQA HEDIS measure moves to align with the clinical American College of Obstetricians and Gynecologists guidelines.

<table><tr><th>Measure</th><th>Measurement Year 2017</th><th>Measurement Year 2018</th></tr><tr><td>Asthma Medication Ratio</td><td>28.24%</td><td>32.38%</td></tr><tr><td>Breast Cancer Screening</td><td>51.35%</td><td>54.00%</td></tr><tr><td>Cervical Cancer Screening</td><td>49.63%</td><td>57.95%</td></tr></table></td></tr>
<tr><td>2. Determine whether or not the MCP should modify or expand previously tested improvement strategies to improve the MCP’s performance to above the minimum performance level for the Use of Imaging Studies for Low Back Pain measure.</td><td>The work Blue Shield Promise did on the Use of Imaging Studies for Low Back Pain measure can likely be leveraged for many different measures. Our quality improvement team worked closely with the provider groups to ensure understanding of the measures, incentives, and care gaps for their assigned members. The training and education were given in a simple way to ensure there was full understanding of the measure at every level within the clinic.</td></tr>
</table>

2017–18 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
3. Monitor the adopted and adapted interventions to achieve optimal outcomes beyond the life of the 2015–17 *Diabetes Blood Pressure Monitoring* and *Cervical Cancer Screening* PIPs. The MCP should apply lessons learned from the 2015–17 PIPs to facilitate improvement of the adopted and adapted interventions.	There were many improvements made to our PIP interventions from the 2015–17 PIPs. The care gap lists and report cards were improved in 2018. Some enhancements were to show less measures from the prior report (all External Accountability Set measures were on the new report card). The lists include the current rate, prior year rate, and how many members the groups had to see to close care gaps to hit the minimum performance level. Additionally, we worked to improve our relationships with the groups and federally qualified health centers within San Diego County. We are learning their barriers to care and are working to help our partners to break down those barriers. We have hired a team within the county to help bring quality improvement to the local health care delivery system. There have been many lessons learned and improvements year over year.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Blue Shield Promise's self-reported actions in Table 9.1 and determined that Blue Shield Promise adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. Blue Shield Promise described actions taken during the review period, results from the MCP's actions to address declining performance, and steps the MCP plans to take moving forward. Actions included both beneficiary and provider strategies, and efforts to address barriers with providers to improve providers' understanding of the measures as well as to assist with addressing the identified barriers.

2018–19 Recommendations

Based on the overall assessment of Blue Shield Promise's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- To address the MCP's continued performance below the minimum performance level for the *Asthma Medication Ratio* measure, assess whether current improvement strategies need to be changed or expanded to ensure that beneficiaries ages 5 to 64 who are identified as having persistent asthma have a ratio of controller medications to total asthma medications of 0.50 or greater.
- To improve the MCP's performance to above the minimum performance level for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure; determine the factors preventing beneficiaries ages 3 to 6 from being seen for one or more well-child visits with a PCP during the measurement year; and identify strategies to address the factors.

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

Appendix G:
Performance Evaluation Report
California Health & Wellness Plan
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, California Health & Wellness Plan ("CHW" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in CHW's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CHW is a full-scope MCP delivering services to beneficiaries under the Regional and Imperial models. In all counties, beneficiaries may enroll in CHW or the other commercial plan.

CHW became operational in to provide MCMC services effective November 1, 2013. Table 1.1 shows the counties in which CHW provides MCMC services, the other commercial plans for each county, CHW's enrollment for each county, the MCP's total number of beneficiaries, and the percentage of beneficiaries enrolled in CHW for each county as of June 2019.[1]

Table 1.1—CHW Enrollment as of June 2019

County	Other Commercial Plan	CHW Enrollment as of June 2019	CHW's Percentage of Beneficiaries Enrolled in the County
Alpine	Anthem Blue Cross Partnership Plan (Anthem)	79	36%
Amador	Anthem Kaiser NorCal	1,271	21%
Butte	Anthem	39,898	63%
Calaveras	Anthem	5,297	56%
Colusa	Anthem	3,120	40%
El Dorado	Anthem Kaiser NorCal	18,519	64%
Glenn	Anthem	7,221	73%
Imperial	Molina Healthcare of California Partner Plan, Inc.	61,660	81%
Inyo	Anthem	1,811	49%
Mariposa	Anthem	885	22%
Mono	Anthem	957	38%
Nevada	Anthem	8,674	43%

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

County	Other Commercial Plan	CHW Enrollment as of June 2019	CHW's Percentage of Beneficiaries Enrolled in the County
Placer	Anthem Kaiser NorCal	9,442	21%
Plumas	Anthem	2,531	50%
Sierra	Anthem	235	42%
Sutter	Anthem	10,527	33%
Tehama	Anthem	11,187	58%
Tuolumne	Anthem	5,289	53%
Yuba	Anthem	9,356	37%
Total		197,959	

Under the Regional model, DHCS allows CHW to combine data from multiple counties to make up two single reporting units—Region 1 and Region 2. The counties within each of these reporting units are as follows:

- **Region 1**— Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama counties
- **Region 2**— Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba counties

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CHW. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the 2017 on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CHW. A&I conducted the audits from December 4, 2017, through December 15, 2017.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CHW
Audit Review Period: December 1, 2016, through November 30, 2017

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	Yes	CAP imposed and findings in this category rectified.
Member's Rights	No	No findings.
Quality Management	Yes	CAP imposed and findings in this category rectified.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	Yes	CAP imposed and findings in this category rectified.

Table 2.2 summarizes the results and status of the 2019 on-site DHCS A&I Medical and State Supported Services Audits of CHW. A&I conducted the audits from February 11, 2019, through February 22, 2019. During the audits, A&I evaluated the effectiveness of the MCP's 2017 CAP. Additionally, the Medical Audit portion was a reduced scope audit, evaluating five categories rather than six.

Table 2.2—DHCS A&I Medical and State Supported Services Audits of CHW
Audit Review Period: December 1, 2017, through November 30, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

During the 2019 Medical and State Supported Services Audits of CHW, A&I's evaluation of the MCP's CAP from the 2017 audits revealed that CHW (1) had improved its procedures to pay out-of-network claims in a timely manner and include interest if the MCP paid the claims late, (2) was conducting MCMC training with new providers within the contract time frames, and (3) had revised the MCP's Evidence of Coverage to be in compliance with the American Academy of Pediatrics v. Lungren decision. During the 2019 audits, A&I identified no findings in the Utilization Management and State Supported Services categories.

During the 2017 Medical and State Supported Services Audits of CHW, A&I identified no findings in the Utilization Management, Case Management and Coordination of Care, Member's Rights, and Administrative and Organizational Capacity categories. Additionally, CHW's response to the MCP's CAP for the findings A&I identified in the Access and Availability of Care, Quality Management, and State Supported Services categories resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

CHW has the opportunity to work with DHCS to ensure that the MCP fully resolves all findings from the 2019 A&I Medical and State Supported Services Audits of CHW. The findings cut across the areas of quality and timeliness of, and access to, health care.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for California Health & Wellness Plan* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that CHW followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.27 for CHW's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.27:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1through Table 3.24 present the performance measure results and findings by domain, and Table 3.25 through Table 3.27 present the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.
- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 through Table 3.3 present the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1 through Table 3.3:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
CHW—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**64.66%**	66.05%	72.24%	69.85%	-2.39
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	96.89%	97.05%	97.09%	95.74%	-1.35

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	91.07%	90.01%	90.09%	87.90%	-2.19
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.57%	88.96%	**87.47%**	**87.01%**	-0.46
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.34%	86.38%	**85.18%**	**84.11%**	-1.07
Immunizations for Adolescents—Combination 2	—	24.82%	38.44%	34.31%	-4.13
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	68.75%	70.24%	65.08%	70.37%	5.29

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	58.17%	63.66%	58.79%	68.64%	9.85
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.67%	73.28%	80.49%	76.67%	-3.82

Table 3.2—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**65.63%**	68.35%	65.28%	**57.45%**	-7.83
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	95.34%	96.32%	95.81%	94.52%	-1.29
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	88.56%	88.54%	87.15%	84.47%	-2.68
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	90.30%	89.40%	87.73%	**87.25%**	-0.48
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.08%	86.58%	**85.29%**	**84.77%**	-0.52
Immunizations for Adolescents—Combination 2	—	20.92%	22.87%	**25.55%**	2.68
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	**46.02%**	60.58%	**56.45%**	**56.45%**	0.00

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	**35.90%**	52.07%	55.47%	55.96%	0.49
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**63.22%**	68.49%	69.44%	**62.43%**	-7.01

Table 3.3—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**53.13%**	**58.05%**	**54.86%**	**45.48%**	-9.38
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**92.36%**	**92.30%**	**91.59%**	**90.76%**	-0.83
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**82.57%**	**82.41%**	**78.06%**	**79.32%**	1.26
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**84.16%**	**83.39%**	**80.62%**	**79.68%**	-0.94
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**82.34%**	**81.87%**	**79.47%**	**79.84%**	0.37
Immunizations for Adolescents—Combination 2	—	17.76%	24.09%	26.52%	2.43
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	**44.82%**	61.07%	61.80%	63.08%	1.28

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	**36.87%**	51.82%	55.72%	55.50%	-0.22
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**58.65%**	**63.34%**	**61.20%**	**59.44%**	-1.76

Table 3.4 through Table 3.6 present findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.4 through Table 3.6:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.4—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHW—Imperial County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.5—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	4	5	80.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	5	40.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	3	4	75.00%

Table 3.6—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	2	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	5	40.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	2	4	50.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Assessment of Corrective Action Plan—Preventive Screening and Children's Health

Based on reporting year 2018 performance measure results, DHCS issued a CAP for CHW. The following measures within the Preventive Screening and Children's Health domain were included in the CAP:

- *Childhood Immunization Status—Combination 3* in Region 2
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* in Region 1
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Region 2

Childhood Immunization Status

The rate was below the minimum performance level for the *Childhood Immunization Status—Combination 3* measure in Region 2 in reporting year 2018; however, because DHCS had already approved CHW to conduct a PIP to address the MCP's continued performance below the minimum performance level for the *Childhood Immunization Status—Combination 3* measure in this region, DHCS did not require the MCP to conduct additional IP activities related to this measure. HSAG includes a summary of CHW's progress on the *Childhood Immunization Status—Combination 3* PIP in Section 4 of this report ("Performance Improvement Projects").

The *Childhood Immunization Status—Combination 3* measure rate in Region 2 declined significantly from reporting year 2018 to reporting year 2019 and remained below the minimum performance level.

Weight Assessment and Counseling for Nutrition and Well-Child Visits

DHCS approved CHW to conduct one set of PDSA cycles to address the MCP's performance below the minimum performance levels for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* measure in Region 1 and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in Region 2.

For both PDSA cycles, CHW tested whether implementing a weekend clinic and offering a beneficiary incentive would result in an increase in the number of well-child visits scheduled and in provider documentation of nutrition counseling. CHW reported learning that communication about the intervention with the clinic staff members ensured that the clinic staff members who were conducting the intervention did so as requested by CHW. Additionally, CHW reported observing varying motivating factors for parents to seek care for their children and noted that conducting a beneficiary survey may provide information to help the MCP better understand the motivating factors.

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* measure rate in Region 1 and *Well-Child Visits in*

the Third, Fourth, Fifth, and Sixth Years of Life measure rate in Region 2 remained below the minimum performance levels in reporting year 2019.

Preventive Screening and Women's Health

Table 3.7 through Table 3.9 present the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.7 through Table 3.9:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.7—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
CHW—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	59.80%	63.79%	62.60%	-1.19
Cervical Cancer Screening	58.60%	60.35%	68.10%	68.89%	0.79
Prenatal and Postpartum Care—Postpartum Care	55.48%	63.64%	61.46%	64.54%	3.08
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**76.46%**	83.54%	85.42%	86.22%	0.80

Table 3.8—Preventive Screening and Women's Health Domain Multi-Year Performance Measure Results CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**49.37%**	**50.57%**	**49.78%**	-0.79
Cervical Cancer Screening	**41.88%**	48.66%	54.99%	**52.57%**	-2.42
Prenatal and Postpartum Care—Postpartum Care	61.14%	64.54%	65.26%	68.62%	3.36
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**72.04%**	83.93%	85.26%	87.77%	2.51

Table 3.9—Preventive Screening and Women's Health Domain Multi-Year Performance Measure Results CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**48.08%**	**47.14%**	**47.84%**	0.70
Cervical Cancer Screening	**44.55%**	52.31%	56.34%	**53.83%**	-2.51
Prenatal and Postpartum Care—Postpartum Care	62.91%	69.07%	67.23%	66.94%	-0.29
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**73.47%**	86.60%	85.59%	83.61%	-1.98

Table 3.10 through Table 3.12 present findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.10 through Table 3.12:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.10—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHW—Imperial County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.11—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.12—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Assessment of Corrective Action Plan—Preventive Screening and Women's Health

As noted previously, based on reporting year 2018 performance measure results, DHCS issued a CAP for CHW. The *Breast Cancer Screening* measure in regions 1 and 2 within the Preventive Screening and Women's Health domain was included in the CAP.

CHW conducted two PDSA cycles to improve the MCP's performance on the *Breast Cancer Screening* measure. For both cycles, CHW tested whether bringing mobile mammography services directly to a clinic and providing a $25 beneficiary incentive for completing a

mammogram would result in an increase in the number of beneficiaries completing a breast cancer screening at their usual provider's office. CHW reported that having MCP staff represented on-site facilitated successful coordination of the intervention tasks. Additionally, CHW reported learning that it was crucial to have bilingual staff members on-site to assist non-English-speaking beneficiaries with the mobile mammography services.

The *Breast Cancer Screening* measure rates in regions 1 and 2 remained below the minimum performance level in reporting year 2019.

Care for Chronic Conditions

Table 3.13 through Table 3.15 present the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.13 through Table 3.15:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.13 through Table 3.15. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.13—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CHW—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.65%	92.98%	94.01%	94.85%	0.84

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	92.57%	92.78%	93.03%	95.99%	2.96
*Asthma Medication Ratio^*	—	72.25%	68.92%	70.88%	1.96
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	65.74%	72.99%	75.91%	69.29%	-6.62
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	65.74%	68.86%	67.40%	65.60%	-1.80
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	45.14%	49.15%	55.23%	56.02%	0.79
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	47.22%	41.12%	33.82%	34.15%	0.33
*Comprehensive Diabetes Care—HbA1c Testing^*	88.89%	88.81%	88.81%	88.21%	-0.60
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	91.20%	92.70%	90.75%	91.89%	1.14
Controlling High Blood Pressure	—	—	—	73.24%	Not Comparable

Table 3.14—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**84.03%**	**84.40%**	**85.43%**	**84.16%**	-1.27

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**83.02%**	85.43%	**82.58%**	**84.74%**	2.16
*Asthma Medication Ratio^*	—	62.13%	62.47%	64.42%	1.95
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	66.67%	65.94%	69.10%	68.78%	-0.32
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**46.99%**	54.01%	56.20%	54.63%	-1.57
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	45.83%	47.20%	52.31%	51.46%	-0.85
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	44.91%	41.36%	36.01%	37.32%	1.31
*Comprehensive Diabetes Care—HbA1c Testing^*	83.33%	83.45%	85.40%	86.10%	0.70
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	84.95%	**84.43%**	**85.89%**	**85.85%**	-0.04
Controlling High Blood Pressure	—	—	—	62.04%	Not Comparable

Table 3.15—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**81.94%**	**81.93%**	**81.85%**	**82.32%**	0.47

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**81.25%**	**82.76%**	**83.49%**	**83.74%**	0.25
*Asthma Medication Ratio^*	—	54.81%	**54.63%**	**53.54%**	-1.09
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	62.27%	62.53%	71.46%	67.64%	-3.82
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**41.20%**	52.80%	50.24%	52.80%	2.56
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	46.30%	54.99%	56.59%	52.07%	-4.52
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	45.14%	34.06%	33.90%	36.98%	3.08
*Comprehensive Diabetes Care—HbA1c Testing^*	83.80%	85.89%	84.39%	**84.43%**	0.04
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	87.27%	88.56%	88.78%	**88.08%**	-0.70
Controlling High Blood Pressure	—	—	—	59.12%	Not Comparable

Table 3.16 through Table 3.18 present findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.16 through Table 3.18:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.16—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CHW—Imperial County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	9	22.22%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	8	25.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Table 3.17—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	3	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	9	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	2	8	25.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	6	0.00%

Table 3.18—Care for Chronic Conditions Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	3	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	5	9	55.56%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	2	8	25.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	6	33.33%

Assessment of Corrective Acton Plan—Care for Chronic Conditions

As noted previously, based on reporting year 2018 performance measure results, DHCS issued a CAP for CHW. The following measures within the Care for Chronic Conditions domain were included in the CAP:

- Both *Annual Monitoring for Patients on Persistent Medications* measures in regions 1 and 2
- *Asthma Medication Ratio* in Region 2
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Region 1

Annual Monitoring for Patients on Persistent Medications and Comprehensive Diabetes Care

CHW conducted PDSA cycles to improve the MCP's performance on the *Annual Monitoring for Patients on Persistent Medications* and *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measures. Initially, CHW implemented one PDSA cycle focused only on the *Annual Monitoring for Patients on Persistent Medications* measures and one PDSA cycle focused only on the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure. Following the individual PDSA cycles, CHW conducted one PDSA cycle to help improve the MCP's performance on both measures. The following is a summary of CHW's PDSA cycles related to these measures:

Plan-Do-Study Act Cycle 1—*Annual Monitoring for Patients on Persistent Medications*

CHW tested whether having the on-site clinical pharmacist place a standing lab order through the clinic's electronic health record (EHR) for beneficiaries who needed to complete their required labs would improve beneficiary compliance. CHW reported learning that having the clinical pharmacist coordinate standing lab orders contributed positively to the clinic's overall *Annual Monitoring for Patients on Persistent Medications* compliance rate among the hardest-to-reach beneficiaries. Additionally, placing standing lab orders further enhanced beneficiary outreach, reduced barriers associated with scheduling appointments, and helped to streamline the clinic's lab processes.

Plan-Do-Study Act Cycle 1—*Comprehensive Diabetes Care*

CHW tested whether partnering with a vendor to mail in-home HbA1c and microalbumin screening kits to beneficiaries who needed to complete their HbA1c and nephropathy testing would improve beneficiary compliance with completing the tests. CHW reported learning that testing an in-home screening intervention in Quarter 4 around the holidays can negatively affect outcomes and that testing the intervention at the end of Quarter 2 or beginning of Quarter 3 may yield better outcomes. Additionally, upon reviewing the follow-up letter, CHW identified opportunities for improvement regarding the wording of the letter to ensure the beneficiaries understood the importance of completing the test within a specified time period.

Combined Plan-Do Study Act Cycle

CHW tested whether implementing gap-in-care reports that identified beneficiaries needing diabetes care as well as beneficiaries needing labs for medication monitoring would improve beneficiary compliance with needed tests and improve the MCP's performance on the *Annual Monitoring for Patients on Persistent Medications* and *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measures. The MCP's diabetes manager conducted beneficiary outreach and case management for beneficiaries with diabetes, and the clinical pharmacist placed standing lab orders for beneficiaries who were due for their *Annual Monitoring for Patients on Persistent Medications* lab testing. CHW reported learning that coordination among the clinic quality improvement lead, diabetes program manager, and clinical pharmacist enhanced internal communication and facilitated beneficiaries closing multiple care gaps. Additionally, conducting data check-ins with the clinic resulted in improved communication and opportunities to identify successes and address barriers.

The rates for both *Annual Monitoring for Patients on Persistent Medications* measures in regions 1 and 2 remained below the minimum performance levels in reporting year 2019. Additionally, the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate in Region 1 remained below the minimum performance level in reporting year 2019.

Asthma Medication Ratio

CHW conducted two PDSA cycles to improve the MCP's performance in Region 2 for the *Asthma Medication Ratio* measure.

For the first PDSA cycle, CHW tested whether having a licensed clinical pharmacist conduct beneficiary outreach using motivational interviewing techniques to review the importance of controller adherence would result in the targeted percentage of beneficiaries filling their asthma controller medication prescriptions. CHW reported learning that providing a concrete list of providers and beneficiaries with a specific time frame, including a deadline, served as a call to action for the MCP's pharmacy partners.

For the second PDSA cycle, CHW tested whether offering to help beneficiaries with asthma schedule follow-up appointments with their primary care providers would result in the targeted percentage of beneficiaries scheduling their appointments. The MCP reported that it planned

to use non-clinical staff recruited from the communities to conduct the beneficiary and provider outreach. CHW reported learning that, based on the number of beneficiaries who indicated intent to schedule their own appointments, the MCP would need to implement a process to evaluate whether those beneficiaries subsequently scheduled and kept their appointments.

CHW also reported that hearing directly from beneficiaries regarding their specific health challenges and concerns resulted in increased MCP awareness about considering those challenges when conducting future outreach, including development of health education materials.

The *Asthma Medication Ratio* measure rate in Region 2 remained below the minimum performance level in reporting year 2019.

Appropriate Treatment and Utilization

Table 3.19 through Table 3.21 present the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.19 through Table 3.21:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent

services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.

- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.19—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
CHW—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or

reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	60.72	58.33	57.42	49.83	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	285.71	290.81	232.88	266.89	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	35.18%	35.97%	32.49%	29.40%	-3.09
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	9.52%	Not Comparable
Use of Imaging Studies for Low Back Pain	**58.50%**	**50.92%**	**62.76%**	67.88%	5.12

Table 3.20—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	54.37	53.99	51.22	50.72	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	348.53	341.25	343.18	341.16	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	**16.59%**	**20.92%**	**15.73%**	**17.89%**	2.16
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	18.08%	Not Comparable
Use of Imaging Studies for Low Back Pain	78.05%	**67.24%**	74.92%	72.06%	-2.86

Table 3.21—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	58.83	56.29	55.37	52.39	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	260.30	263.87	260.20	266.37	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	27.46%	28.27%	26.51%	33.00%	6.49
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	12.02%	Not Comparable
Use of Imaging Studies for Low Back Pain	75.30%	**66.82%**	75.97%	72.26%	-3.71

Table 3.22 through Table 3.24 present findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.22—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHW—Imperial County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	1	0.00%

Table 3.23—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	2	50.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	1	0.00%

Table 3.24—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Assessment of Corrective Action Plan—Appropriate Treatment and Utilization

As noted previously, based on reporting year 2018 performance measure results, DHCS issued a CAP for CHW. The following measures within the Appropriate Treatment and Utilization domain were included in the CAP:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Region 1
- *Use of Imaging Studies for Low Back Pain* in Imperial County

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

CHW conducted two PDSA cycles to improve the MCP's performance in Region 1 for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure.

For the first PDSA cycle, CHW tested whether conducting monthly multidisciplinary team meetings as a follow-up to the Alliance Working for Antibiotic Resistance Education (AWARE) prescription pad intervention initiated on January 29, 2018, to review and analyze results, initiate feedback, and conduct retraining would help to improve the MCP's performance. CHW reported that some providers were resistant to change and that using the prescription pad was an administrative burden for the providers. Additionally, CHW identified opportunities for additional provider training on effective communication skills for responding to beneficiary demand and expectations related to antibiotic prescriptions.

For the second PDSA cycle, CHW tested whether having the clinic partner's leadership use the Robert Wood Johnson Foundation Virtual Clinic Simulation would result in increased participation in the simulations and allow the MCP to expand the learning opportunities available to providers. CHW indicated that the clinic partner reported a decrease in the number of beneficiaries diagnosed with acute bronchitis during the summer months, which was consistent with trends observed in prior years. The MCP therefore determined that intervention efforts related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure should instead occur during the cold and flu season.

The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure rate in Region 1 remained below the minimum performance level in reporting year 2019.

Use of Imaging Studies for Low Back Pain

CHW conducted two PDSA cycles to improve the MCP's performance for the *Use of Imaging Studies for Low Back Pain* measure in Imperial County.

For the first PDSA cycle, CHW tested whether implementing a modification to the provider partner's inpatient EHR that required the presence of "red flags" for placing imaging study orders would help to improve appropriate ordering of imaging studies for diagnoses of low back pain in the inpatient setting.

For the second PDSA cycle, CHW modified the provider partner's outpatient EHR template to include low back pain screening guidelines. Additionally, the MCP conducted mandatory

provider training to increase provider knowledge of low back pain treatment guidelines and the modified EHR template.

As a result of both PDSA cycles, CHW reported learning that active provider leadership participation served as a model for provider behavior change. Additionally, the MCP indicated learning that score cards are a useful evaluation tool for providers and that the score cards help CHW to determine whether additional training is needed.

The *Use of Imaging Studies for Low Back Pain* measure rate in Imperial County improved significantly from reporting year 2018 to reporting year 2019, resulting in the rate moving to above the minimum performance level in reporting year 2019.

Performance Measure Findings—All Domains

Table 3.25 through Table 3.27 present a summary of CHW's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.25 through Table 3.27:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.25—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains CHW—Imperial County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	19	10.53%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	19	15.79%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	18	0.00%

Table 3.26—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	6	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	9	19	47.37%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	3	19	15.79%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	3	16	18.75%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	3	13	23.08%

Table 3.27—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	6	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	8	19	42.11%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	2	19	10.53%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	4	16	25.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	13	15.38%

Corrective Action Plan Requirements for 2019

The following measures with rates below the minimum performance levels in reporting year 2019 will be included in CHW's CAP:

- *Asthma Medication Ratio* in Region 2
- *Breast Cancer Screening* in regions 1 and 2
- *Childhood Immunization Status—Combination 3* in regions 1 and 2
- *Comprehensive Diabetes Care—HbA1c Testing* in Region 2
- *Immunizations for Adolescents—Combination 2* in Region 1
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in regions 1 and 2

Note that while the rates for the following measures were below the minimum performance levels in reporting year 2019, these measures will not be included in CHW's CAP. This is due to DHCS not requiring MCPs to report rates for these measures in reporting year 2020.

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Region 1
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in regions 1 and 2
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* in Region 1

While the rates for both *Annual Monitoring for Patients on Persistent Medications* measures were below the minimum performance levels in regions 1 and 2 in reporting year 2019, DHCS will not include these measures in CHW's CAP due to the small range of variation between the high performance level and minimum performance level thresholds for each measure.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.28 through Table 3.30 present the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.31 through Table 3.33 present the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.34 through Table 3.36 present the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.34 through Table 3.36.

Table 3.28—Multi-Year SPD Performance Measure Trend Table
CHW—Imperial County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	101.51	96.35	107.06	86.55	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	540.67	582.11	697.25	675.16	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	94.46%	93.70%	95.89%	96.97%	1.08
Annual Monitoring for Patients on Persistent Medications—Diuretics	94.72%	94.34%	96.07%	97.88%	1.81
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	92.09%	95.73%	86.05%	92.09%	6.04
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA	97.00%	94.12%	91.40%	-2.72
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA	93.75%	92.11%	91.22%	-0.89
*Plan All-Cause Readmissions***	—	—	—	15.43%	Not Comparable

Table 3.29—Multi-Year SPD Performance Measure Trend Table
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	87.91	89.02	85.96	83.80	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	599.31	591.80	608.45	601.79	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.51%	87.17%	89.13%	88.29%	-0.84
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.54%	88.69%	89.03%	89.05%	0.02
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	91.49%	93.21%	91.57%	90.24%	-1.33
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	95.35%	92.46%	91.71%	93.40%	1.69
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	95.65%	86.17%	83.01%	87.19%	4.18
*Plan All-Cause Readmissions***	—	—	—	23.17%	Not Comparable

Table 3.30—Multi-Year SPD Performance Measure Trend Table CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	88.42	87.04	94.83	83.91	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	444.22	443.12	478.32	483.15	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.08%	87.64%	86.61%	85.51%	-1.10
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.40%	87.05%	88.95%	88.28%	-0.67
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	65.38%	83.91%	81.08%	83.58%	2.50
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	88.24%	81.55%	81.08%	75.21%	-5.87

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	90.00%	82.11%	75.28%	79.14%	3.86
*Plan All-Cause Readmissions***	—	—	—	15.14%	Not Comparable

Table 3.31—Multi-Year Non-SPD Performance Measure Trend Table
CHW—Imperial County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	58.09	55.87	56.07	48.67	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	269.30	271.92	220.16	254.03	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.61%	92.86%	93.74%	94.54%	0.80
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.66%	92.46%	92.51%	95.64%	3.13
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	96.88%	97.03%	97.06%	95.73%	-1.33
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	91.04%	89.91%	90.17%	87.82%	-2.35
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.53%	88.82%	87.31%	86.88%	-0.43

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.32%	86.28%	85.09%	84.00%	-1.09
*Plan All-Cause Readmissions***	—	—	—	8.31%	Not Comparable

Table 3.32—Multi-Year Non-SPD Performance Measure Trend Table
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	50.39	49.77	47.81	47.30	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	318.81	311.04	317.14	314.21	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.17%	82.98%	83.58%	82.14%	-1.44
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.73%	83.42%	78.71%	82.17%	3.46
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	95.33%	96.37%	95.79%	94.51%	-1.28
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	88.51%	88.44%	87.04%	84.34%	-2.70
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	90.26%	89.30%	87.60%	87.06%	-0.54

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.01%	86.60%	85.41%	84.66%	-0.75
*Plan All-Cause Readmissions***	—	—	—	14.39%	Not Comparable

Table 3.33—Multi-Year Non-SPD Performance Measure Trend Table
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	56.02	53.27	52.29	49.81	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	242.81	246.30	243.18	248.65	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	79.79%	79.56%	79.89%	81.05%	1.16
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.85%	80.85%	81.12%	81.77%	0.65
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	92.44%	92.27%	91.54%	90.72%	-0.82
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	82.81%	82.39%	78.01%	79.26%	1.25
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	84.12%	83.43%	80.61%	79.79%	-0.82

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	82.29%	81.86%	79.59%	79.86%	0.27
*Plan All-Cause Readmissions***	—	—	—	10.27%	Not Comparable

Table 3.34—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CHW—Imperial County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	86.55	48.67	Not Tested	49.83
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	675.16	254.03	Not Tested	266.89
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	96.97%	94.54%	2.43	94.85%
Annual Monitoring for Patients on Persistent Medications—Diuretics	97.88%	95.64%	2.24	95.99%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	95.73%	Not Comparable	95.74%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	92.09%	87.82%	4.27	87.90%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.40%	86.88%	4.52	87.01%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	91.22%	84.00%	7.22	84.11%
*Plan All-Cause Readmissions***	15.43%	8.31%	7.12	9.52%

Table 3.35—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	83.80	47.30	Not Tested	50.72
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	601.79	314.21	Not Tested	341.16
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.29%	82.14%	6.15	84.16%
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.05%	82.17%	6.88	84.74%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	94.51%	Not Comparable	94.52%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	90.24%	84.34%	5.90	84.47%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	93.40%	87.06%	6.34	87.25%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.19%	84.66%	2.53	84.77%
*Plan All-Cause Readmissions***	23.17%	14.39%	8.78	18.08%

Table 3.36—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	83.91	49.81	Not Tested	52.39
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	483.15	248.65	Not Tested	266.37
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.51%	81.05%	4.46	82.32%
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.28%	81.77%	6.51	83.74%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	90.72%	Not Comparable	90.76%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.58%	79.26%	4.32	79.32%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	75.21%	79.79%	-4.58	79.68%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	79.14%	79.86%	-0.72	79.84%
*Plan All-Cause Readmissions***	15.14%	10.27%	4.87	12.02%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that CHW stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, CHW had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019.

- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019:
  - The reporting year 2019 non-SPD rate was significantly better than the reporting year 2018 non-SPD rate for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure in Imperial County.
  - The reporting year 2019 non-SPD rates were significantly worse than the reporting year 2018 non-SPD rates for the following measures:
    - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Imperial County and Region 1
    - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Imperial County
- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
    - Both *Annual Monitoring for Patients on Persistent Medications* measures in regions 1 and 2
    - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Region 1
    - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Region 1
    - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Imperial County
  - The reporting year 2019 SPD rates were significantly worse than the reporting year 2019 non-SPD rates for the *Plan All-Cause Readmissions* measure in all three reporting units. Note that the higher rates of hospital readmissions for the SPD population are expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that CHW followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Across all domains and reporting units, HSAG identified the following notable reporting year 2019 performance measure results for CHW:

- CHW performed the best in Imperial County, with this reporting unit having no rates below the minimum performance levels in reporting year 2019.
- The rates for both *Annual Monitoring for Patients on Persistent Medications* measures in Imperial County were above the high performance levels for the last three or more consecutive years.

- The rates for the following measures improved significantly from reporting year 2018 to reporting year 2019:
  - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Imperial County
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Region 2
  - *Use of Imaging Studies for Low Back Pain* in Imperial County, resulting in the rate for this measure moving from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019.
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total* in Imperial County

Opportunities for Improvement—Performance Measures

Across all domains and reporting units, 17 of 57 rates for which CHW was held accountable to meet the MPLs in reporting year 2019 (30 percent) were below the MPLs. Region 1 had nine of 19 measures (47 percent) with rates below the minimum performance levels, and Region 2 had eight of 19 measures (42 percent) with rates below the minimum performance levels.

Performance measure results show that CHW has the most opportunities for improvement related to the following six measures with rates below the minimum performance levels in reporting year 2019:

- *Asthma Medication Ratio* in Region 2
- *Breast Cancer Screening* in regions 1 and 2
- *Childhood Immunization Status—Combination 3* in regions 1 and 2
- *Comprehensive Diabetes Care—HbA1c Testing* in Region 2
- *Immunizations for Adolescents—Combination 2* in Region 1
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in regions 1 and 2

CHW should assess whether the MCP's current improvement strategies for the six measures listed above need to be modified or expanded to improve the MCP's performance to above the minimum performance levels.

In addition to the measures listed previously with rates below the minimum performance levels in reporting year 2019, the rates for the following three measures were below the minimum performance levels in reporting year 2019:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Region 1
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in regions 1 and 2
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* in Region 1

Note that HSAG makes no formal recommendations for these three measures because DHCS will not require MCPs to report the measures to DHCS in reporting year 2020, and DHCS and

HSAG will therefore have no way to follow up on the outcomes of the MCP's quality improvement actions related to the measures.

Additionally, while the rates for both *Annual Monitoring for Patients on Persistent Medications* measures were below the minimum performance levels in regions 1 and 2 in reporting year 2019, HSAG makes no formal recommendations to the MCP related to these measures due to the small range of variation between the high performance level and minimum performance level thresholds for each measure.

DHCS and HSAG expect that CHW will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCP will conduct improvement activities, as applicable, related to all measures with rates below the minimum performance levels in reporting year 2019.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, CHW conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required CHW to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, CHW identified controlling blood pressure among Hispanic beneficiaries as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—CHW *Controlling Blood Pressure* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of controlled blood pressure among Hispanic beneficiaries diagnosed with hypertension at Health Center A and Health Center B (both in Region 2)[6]	73.2%	91.0%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Controlling Blood Pressure* Disparity PIP. Upon initial review of the module, HSAG determined that CHW met some required validation criteria; however, HSAG identified opportunities for improvement related to considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, CHW incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3

Intervention Testing

Prior to the intervention testing phase of the MCP's *Controlling Blood Pressure* Disparity PIP, HSAG reviewed and provided feedback to CHW on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CHW that the MCP should

[6] Health center names removed for confidentiality.

incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the interventions that CHW tested for its *Controlling Blood Pressure* Disparity PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

Table 4.2—CHW *Controlling Blood Pressure* Disparity PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Deliver controlling blood pressure text messages to remind beneficiaries to schedule an appointment to have their blood pressure checked.	♦ Beneficiaries do not seek care. ♦ Beneficiaries do not understand the diagnosis of hypertension. ♦ Beneficiaries are overwhelmed by the initial diagnosis. ♦ Beneficiaries do not keep appointments.
Provide clinic partners with provider profiles, which are trackable care gap reports.	♦ Beneficiaries have a difficult time accessing appointments due to long wait times which can impact their work schedules. ♦ Beneficiaries are overwhelmed by the initial diagnosis. ♦ Beneficiaries do not keep appointments.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CHW to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although CHW completed testing the interventions through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CHW's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required CHW to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, CHW selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—CHW *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate for *Childhood Immunization Status—Combination 3* measure for Clinic A[7]	42.71%	58.00%

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 3* PIP, HSAG reviewed and provided feedback to CHW on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CHW that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the interventions that CHW tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the failure modes that each intervention addressed.

Table 4.4—CHW *Childhood Immunization Status—Combination 3* PIP Intervention Testing

Intervention	Failure Modes Addressed
Implement monthly immunization clinics at Clinic A.	♦ Impacted schedules at the clinic. ♦ Long wait times for beneficiaries to schedule appointments for immunizations.
Provide $50 gift card incentives to eligible beneficiaries at Clinic A for timely completion of the immunization series.	♦ Appointment cancellations. ♦ Parents are unable to keep the appointments.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CHW and conducted technical assistance calls with MCP staff members to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

[7] Clinic name removed for confidentiality.

Although CHW completed testing the interventions through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CHW's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, CHW submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on CHW's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[8] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with CHW, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from CHW's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of CHW's self-reported actions.

Table 8.1—CHW's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP meets all CAP requirements in Region 2; and apply applicable lessons learned from PDSA cycles, PIPs, and other quality improvement activities to identify improvement strategies to address the MCP's consecutive years of performance below the minimum performance levels for the following measures: a. Both *Annual Monitoring for Patients on Persistent Medications* measures b. *Childhood Immunization Status—Combination 3* c. *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	DHCS and CHW have been working together and addressing all CAP requirements in Region 2. From July 1, 2018, through June 30, 2019, multiple projects and quality improvement initiatives were implemented to address health care outcomes for members needing immunizations and well-child visits, as well as adults on critical medications who require lab work. Those interventions included: *a. Annual Monitoring for Patients on Persistent Medications* ■ Identified and placed standing orders in the EHR for members who had not completed their required *Annual Monitoring for Patients on Persistent Medications* labs. ■ Automated call or text message reminder made to members once orders were placed.

2017–18 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	■ Implemented an in-home health assessment program in geographical areas with high volumes of members. *b. Childhood Immunizations* ■ Continued the member incentive for all CHW regions through member mailings and select point of care clinic distribution. ■ Implemented member interactive voice response call reminder and appointment scheduling calls. *c. Well-Child Visits* ■ Collaborated with clinic sites to host clinic events, including on weekends, to address and close care gaps.
2. For the following measures, assess the causes for the MCP's declining performance or performance below the minimum performance levels; and apply applicable lessons learned from PDSA cycles, PIPs, and other quality improvement activities to identify strategies to improve the MCP's performance: a. Both *Annual Monitoring for Patients on Persistent Medications* measures (Region 1) b. *Asthma Medication Ratio* (Region 2) c. *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* (Region 1) d. *Breast Cancer Screening (regions 1 and 2)*	CHW has assessed the multiple causes and significant issues driving declining performance in certain HEDIS measures. ♦ Lack of provider knowledge and training on HEDIS technical specifications and requirements. ♦ Access to care issues for rural areas. ♦ Data sharing between the MCP and provider. ♦ Lack of member education on health care topics and recommended screenings. CHW applied lessons learned from quality improvement activities to apply strategies to improve MCP performance. Strategies included: ♦ Improving access to care for members: ■ In-home visits and assessments ■ Mailed lab kits

2017–18 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
e. *Comprehensive Diabetes Care—Medical Attention for Nephropathy* (Region 1) f. *Use of Imaging Studies for Low Back Pain* (Imperial County) g. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* (Region 1)	▪ Mobile mammography events ▪ Collaboration with clinics to host expanded hour clinics and clinic events ♦ Improving provider understanding of HEDIS technical specifications. ♦ Improving data sharing between the MCP and provider (i.e., member care gap reports that help identify non-compliant members). ♦ Improving member engagement via: ▪ Member outreach reminders and appointment scheduling. ▪ Member incentives on low-scoring measures.
3. Monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2015–17 *Cervical Cancer Screening* PIP. The MCP should apply lessons learned from the 2015–17 *Cervical Cancer Screening* PIP to facilitate improvement of the adapted intervention.	The MCP has used the findings and lessons learned from the 2015–17 *Cervical Cancer Screening* PIP to strengthen and support cervical cancer screening initiatives in the region. The provider incentive program was continued and adapted to better suit providers and the expectations of cervical cancer screening completion. To supplement the provider incentive, CHW offered a $25 gift card to members who completed a cervical cancer screening. The MCP also conducted the following programs to improve cervical cancer screening rates in the region: ♦ A non-clinical in-home visit team completed outreach to remind members with care gaps about the services for which they are due, educated members on the importance of staying up to date, and assisted members with other supportive needs related to social determinants of health. ♦ An outreach team conducted live calls to members with two or more care gaps, including cervical cancer screening, to educate the member and provide

2017–18 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	scheduling support when the member opted in. ♦ During a mobile mammography event, providers were present for members who were also due for cervical cancer screenings. Members who completed their cervical cancer screening that day received an incentive at the point of care.
4. Apply the lessons learned from the 2015–17 *Immunizations of Two-Year-Olds* PIP in the MCP's 2017–19 *Childhood Immunization Status—Combination 3* PIP.	CHW has incorporated lessons learned from the 2015–17 *Immunizations of Two-Year-Olds* PIP in current PIP and quality improvement activities. ♦ The Provider Engagement team conducted monthly HEDIS webinars to ensure all staff members clearly understand the measure specifications. ♦ HEDIS tip sheets were developed and shared with CHW providers. *Childhood Immunization Status—Combination 3* tip sheets were made available for clinic providers and staff during the 2017–19 *Childhood Immunization Status—Combination 3* PIP. ♦ The MCP completed an assessment of cultural barriers that were incorporated into the 2017–19 PIP Initiation and Intervention Determination Phase. ♦ A clinic partner was involved during all phases of identifying and developing the PIP intervention to ensure that the intervention was aligned with the clinic capacity and that goals were attainable.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CHW's self-reported actions in Table 8.1 and determined that CHW adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. CHW described specific interventions the MCP implemented to improve performance to above the minimum performance levels or prevent further decline in performance, and actions taken based on lessons learned. Some of the MCP's described actions may have contributed to the improvement HSAG noted in Section 3 of this report ("Managed Care Health Plan Performance Measures") under the Strengths—Performance Measures heading.

2018–19 Recommendations

Based on the overall assessment of CHW's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to ensure that the MCP fully resolves all findings from the 2019 A&I Medical and State Supported Services Audits.
- For the following six measures with rates below the minimum performance levels in reporting year 2019, assess whether the MCP's current improvement strategies need to be modified or expanded to improve the MCP's performance to above the minimum performance levels:
  - *Asthma Medication Ratio* in Region 2
  - *Breast Cancer Screening* in regions 1 and 2
  - *Childhood Immunization Status—Combination 3* in regions 1 and 2
  - *Comprehensive Diabetes Care—HbA1c Testing* in Region 2
  - *Immunizations for Adolescents—Combination 2* in Region 1
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in regions 1 and 2

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix H:
Performance Evaluation Report
CalOptima
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, CalOptima (or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in CalOptima's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CalOptima is a full-scope MCP delivering services to beneficiaries in the County Organized Health System model.

CalOptima became operational to provide MCMC services in Orange County effective October 1995. As of June 2019, CalOptima had 733,957 beneficiaries in Orange County. [1]

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CalOptima. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CalOptima. A&I conducted the audits from February 26, 2018, through March 9, 2018.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CalOptima
Audit Review Period: February 1, 2017, through January 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	Yes	CAP imposed and findings in this category rectified.
Access and Availability of Care	No	No findings.
Member's Rights	No	No findings.
Quality Management	No	No findings.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Table 2.2 summarizes the results and status of the on-site DHCS A&I Medical and State Supported Services Audits of CalOptima. A&I conducted the audits from February 4, 2019, through February 15, 2019. The Medical Audit was a reduced scope audit during which A&I evaluated five categories of performance (Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management.

Table 2.2—DHCS A&I Medical and State Supported Services Audits of CalOptima Audit Review Period: February 1, 2018, through January 31, 2019

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	No	No findings.
Quality Management	Yes	CAP in process and under review.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified a finding in only one category (Case Management and Coordination of Care) during the February 26, 2018, through March 9, 2018, Medical and State Supported Services Audits of CalOptima. CalOptima fully rectified the finding in this category. Additionally, during the February 2019 Medical and State Supported Services Audits of CalOptima, A&I identified no findings in the Utilization Management, Member's Rights, and State Supported Services categories.

Opportunities for Improvement—Compliance Reviews

CalOptima has the opportunity to work with DHCS to ensure that the MCP fully resolves all findings from the February 2019 Medical and State Supported Services Audits. The findings cut across the areas of quality and timeliness of, and access to, health care.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for CalOptima* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that CalOptima followed the appropriate specifications to produce valid rates; however, the auditor indicated that the MCP should:

- Improve the MCP's processes for how it ensures that the MCP's systems accurately reflect providers' relationships with federally qualified health centers (FQHCs) and that the MCP's data mapping accurately reflects the relationships at the provider and FQHC levels. In particular, the MCP should ensure that its data mapping accurately reflects instances for which the FQHC is mapped as a primary care provider (PCP).
- Develop a process to systematically document all data sources and track data volume counts from the point of entry into the MCP's enterprise systems to the point of inputting the data in the measure calculation tool. Additionally, the MCP should document all data sources in the HEDIS Record of Administration, Data Management, and Processes (Roadmap) so that the auditor has complete information to review during the approval process.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for CalOptima's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.
- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance

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

levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

Table 3.1—Preventive Screening and Children's Health Domain Multi-Year Performance Measure Results CalOptima—Orange County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	71.46%	72.22%	74.94%	73.84%	-1.10
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**93.08%**	94.14%	93.44%	94.08%	0.64

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.29%	87.69%	87.63%	87.72%	0.09
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	90.62%	90.27%	90.67%	91.26%	0.59
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.48%	86.67%	87.32%	88.14%	0.82
Immunizations for Adolescents—Combination 2	—	34.72%	49.39%	50.24%	0.85
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	84.06%	85.48%	87.10%	82.22%	-4.88
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	73.01%	80.91%	80.65%	80.37%	-0.28

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.70%	79.21%	83.15%	79.17%	-3.98

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CalOptima—Orange County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	5	40.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	4	25.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
CalOptima—Orange County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	64.40%	63.73%	63.78%	0.05
Cervical Cancer Screening	**53.58%**	52.93%	60.24%	63.04%	2.80
Prenatal and Postpartum Care—Postpartum Care	61.02%	69.01%	71.75%	66.67%	-5.08
Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.15%	84.98%	86.16%	84.21%	-1.95

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CalOptima—Orange County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CalOptima—Orange County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.50%	88.90%	89.39%	89.31%	-0.08
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.05%	88.52%	88.46%	88.65%	0.19
*Asthma Medication Ratio^*	—	66.78%	63.71%	69.04%	5.33
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	71.05%	71.63%	72.26%	75.00%	2.74
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	59.37%	63.49%	65.94%	64.06%	-1.88

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	54.01%	57.21%	63.99%	64.58%	0.59
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	34.31%	32.09%	22.87%	27.08%	4.21
*Comprehensive Diabetes Care—HbA1c Testing^*	84.18%	86.98%	90.75%	89.32%	-1.43
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	89.54%	90.93%	91.73%	91.67%	-0.06
Controlling High Blood Pressure	—	—	—	71.05%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CalOptima—Orange County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	9	22.22%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
CalOptima—Orange County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	33.08	32.73	34.47	33.40	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	238.83	242.24	268.01	319.86	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	**21.64%**	22.44%	25.05%	27.69%	2.64
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	16.28%	Not Comparable
Use of Imaging Studies for Low Back Pain	76.10%	73.33%	70.50%	70.89%	0.39

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CalOptima—Orange County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of CalOptima's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
CalOptima—Orange County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	4	19	21.05%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	19	0.00%

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table CalOptima—Orange County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.12.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	50.02	46.55	46.55	44.21	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	495.20	491.25	556.31	623.15	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.83%	90.95%	91.92%	91.46%	-0.46
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.14%	92.20%	92.24%	92.56%	0.32
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	70.09%	86.27%	89.32%	93.42%	4.10
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.01%	84.34%	87.76%	87.13%	-0.63
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.29%	85.99%	87.74%	88.19%	0.45

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	79.16%	81.38%	82.35%	82.84%	0.49
*Plan All-Cause Readmissions***	—	—	—	21.28%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
CalOptima—Orange County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	31.65	31.53	33.47	32.51	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	217.20	220.63	244.14	295.01	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.14%	87.74%	87.95%	88.14%	0.19
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.17%	86.41%	86.32%	86.45%	0.13
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	93.27%	94.20%	93.47%	94.08%	0.61
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.39%	87.77%	87.63%	87.73%	0.10
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	90.80%	90.44%	90.78%	91.37%	0.59

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.82%	86.87%	87.50%	88.34%	0.84
*Plan All-Cause Readmissions***	—	—	—	14.87%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CalOptima—Orange County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	44.21	32.51	Not Tested	33.40

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	623.15	295.01	Not Tested	319.86
Annual Monitoring for Patients on Persistent Medications— ACE Inhibitors or ARBs	91.46%	88.14%	3.32	89.31%
Annual Monitoring for Patients on Persistent Medications— Diuretics	92.56%	86.45%	6.11	88.65%
Children and Adolescents' Access to Primary Care Practitioners— 12–24 Months	93.42%	94.08%	-0.66	94.08%
Children and Adolescents' Access to Primary Care Practitioners— 25 Months–6 Years	87.13%	87.73%	-0.60	87.72%
Children and Adolescents' Access to Primary Care Practitioners— 7–11 Years	88.19%	91.37%	-3.18	91.26%
Children and Adolescents' Access to Primary Care Practitioners— 12–19 Years	82.84%	88.34%	-5.50	88.14%
*Plan All-Cause Readmissions***	21.28%	14.87%	6.41	16.28%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that CalOptima stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, CalOptima had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *7–11 Years*, and *12–19 Years* measures.

- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rate was significantly better than the reporting year 2019 non-SPD rate for both *Annual Monitoring for Patients on Persistent Medications* measures.
  - The reporting year 2019 SPD rate was significantly worse than the reporting year 2019 non-SPD rate for the following measures:
    - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*. The significant differences in rates for these measures may be attributed to beneficiaries in these age groups in the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from PCPs.
    - *Plan All-Cause Readmissions*. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that CalOptima followed the appropriate specifications to produce valid rates.

HSAG identified the following notable reporting year 2019 performance measure results for CalOptima:

- Across all domains, CalOptima performed above the high performance levels for four of 19 measures (21 percent) and had no rates below the minimum performance levels.
  - The rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total* measure was above the high performance level for the last three or more consecutive years.
- The rates for the following measures improved significantly from reporting year 2018 to reporting year 2019:
  - *Asthma Medication Ratio*
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

Opportunities for Improvement—Performance Measures

Based on HSAG's HEDIS Compliance Audit of CalOptima for the required performance measures, the MCP has the opportunity to:

- Improve the MCP's processes for how it ensures that the MCP's systems accurately reflect providers' relationships with FQHCs and that the MCP's data mapping accurately reflects the relationships at the provider and FQHC levels. In particular, the MCP should ensure

that its data mapping accurately reflects instances for which the FQHC is mapped as a PCP.

- Develop a process to systematically document all data sources and track data volume counts from the point of entry into the MCP's enterprise systems to the point of inputting the data in the measure calculation tool. Additionally, the MCP should document all data sources in the Roadmap so that the auditor has complete information to review during the approval process.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to CalOptima's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that CalOptima report rates for three HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for reporting years 2017 through 2019. The reporting year is the year in which the MLTSSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Although reporting year 2016 was the first year that DHCS required MLTSSPs to report rates, DHCS did not require CalOptima to report MLTSS rates in reporting year 2016 because CalOptima became operational as an MLTSSP in late 2015 and therefore did not have a full year of data to report. Reporting year 2017 was the first year that DHCS required CalOptima to report MLTSSP performance measure rates.

Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between reporting year 2018 and reporting year 2019. Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of those changes.

Table 4.1—Multi-Year MLTSSP Performance Measure Results
CalOptima—Orange County

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	61.81	60.10	56.15	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	806.24	925.30	1081.17	Not Tested
Medication Reconciliation Post-Discharge	24.35%	28.71%	29.68%	0.97

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure showed no statistically significant change from reporting year 2018 to reporting year 2019.

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, CalOptima conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required CalOptima to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, CalOptima identified diabetes poor HbA1c control among beneficiaries residing in the city of Santa Ana as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.1—CalOptima *Diabetes Poor HbA1c Control* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of poor or uncontrolled blood glucose levels (HbA1c >9.0 percent) among beneficiaries living with diabetes, 18 to 75 years of age, at two targeted provider offices in Santa Ana.	62.50%	52.31%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Diabetes Poor HbA1c Control* Disparity PIP. Upon initial review of the module, HSAG determined that CalOptima met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the FMEA.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the potential interventions' reliability and sustainability.

After receiving technical assistance from HSAG, CalOptima incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Diabetes Poor HbA1c Control* Disparity PIP, HSAG reviewed and provided feedback to CalOptima on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CalOptima that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.2 presents a description of the interventions that CalOptima tested for its *Diabetes Poor HbA1c Control* Disparity PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

Table 5.2—CalOptima *Diabetes Poor HbA1c Control* Disparity PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Use health coaches to outreach to beneficiaries to encourage the use of CalOptima disease management services.	♦ Beneficiary education. ♦ Beneficiary engagement. ♦ Beneficiary resources. ♦ Beneficiaries are not interested in understanding the information provided on diabetes management.
Obtain monthly data of provider offices A & B[6] to identify beneficiaries needing their HbA1c tests and share this list with provider offices A & B to conduct outreach.	♦ Provider awareness. ♦ Identification of beneficiaries with an HbA1c > 9.0 or missing the HbA1c test. ♦ Provider does not promote the importance of HbA1c testing or educate the beneficiaries on the importance of HbA1c testing.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CalOptima and conducted technical assistance calls with the MCP staff members to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although CalOptima completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CalOptima's 2019–20 MCP-specific evaluation report.

[6] Provider office names removed for confidentiality.

DHCS-Priority Performance Improvement Project

DHCS required CalOptima to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. However, based on CalOptima demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. CalOptima selected adults' access to preventive and ambulatory health services as its 2017–19 DHCS-priority PIP topic based on its MCP-specific data.

Table 5.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.3—CalOptima *Adults' Access to Preventive and Ambulatory Health Services* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of adults' access to preventive and ambulatory health services among beneficiaries ages 45 to 64 assigned to two targeted provider offices	47.18%	78.02%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the MCP's *Adults' Access to Preventive and Ambulatory Health Services* PIP. Upon initial review of the module, HSAG determined that CalOptima met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Including all required components of the FMEA.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the potential interventions' reliability and sustainability.

After receiving technical assistance from HSAG, CalOptima incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Adults' Access to Preventive and Ambulatory Health Services* PIP, HSAG reviewed and provided feedback to CalOptima on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CalOptima that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.4 presents a description of the interventions that CalOptima tested for its *Adults' Access to Preventive and Ambulatory Health Services* PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

Table 5.4—CalOptima *Adults' Access to Preventive and Ambulatory Health Services* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Provide incentives to provider offices A & B[7] staff members for being more proactive in outreach and to be more accurate and timelier in submitting claims/encounters for each visit.	♦ Provider awareness. ♦ Staffing resources/availability. ♦ Provider office staff members are not engaged.
Provide incentives to beneficiaries to attend and complete their preventive health care services at provider offices A & B.	♦ Beneficiary resources. ♦ Beneficiary is more concerned with social determinants than preventive health care services.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CalOptima and conducted technical assistance calls with MCP staff members to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although CalOptima completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CalOptima's 2019–20 MCP-specific evaluation report.

[7] Provider office names removed for confidentiality.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, CalOptima submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on CalOptima's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

7. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[8] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

8. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with CalOptima, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

9. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 9.1 provides EQR recommendations from CalOptima's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 9.1 to preserve the accuracy of CalOptima's self-reported actions.

Table 9.1—CalOptima's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Assess the causes for the rate declining significantly from reporting year 2017 to reporting year 2018 for the *Asthma Medication Ratio* measure and identify strategies to ensure that beneficiaries ages 5 to 64 who are identified as having persistent asthma have a ratio of controller medications to total asthma medications of 0.50 or greater.	CalOptima's Disease Management (DM) program paused regular identification of members with persistent asthma to make data improvements to the program identification methodology. During that time, DM health coach interventions for members with persistent asthma, including members in the HEDIS denominator for the *Asthma Medication Ratio* measure, were greatly reduced. Regular program identification has since resumed, and DM health coaches are providing regular interventions with members. Additionally, targeted mail campaigns have been initiated for members with recent emergency department visits and evidence of short-acting beta agonist and no controller medication.

2017–18 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
2. Assess whether or not current strategies need to be modified or expanded to prevent the rate for the *Use of Imaging Studies for Low Back Pain* measure from continuing to decline.	CalOptima is always looking for opportunities to prevent the rate for *Use of Imaging Studies for Low Back Pain* measure from continual decline. During the period of July 1, 2018, through June 30, 2019, CalOptima's Population Health Management Department (formerly Health Education and Disease Management) worked with the Utilization Management Department to identify members with authorizations pending for low back pain treatments. These members received educational information on other strategies for relieving back pain. The goal was to reduce the rate of imaging study requests through education.
3. Continue monitoring adapted and adopted interventions and outcomes to facilitate improvement beyond the life of the 2015–17 *Diabetes HbA1c Testing* and *Initial Health Assessment* PIPs.	CalOptima continued its efforts in implementing quality initiatives to improve the *Comprehensive Diabetes Care* measure. Initiatives were tracked and monitored monthly using various data sources, including but not limited to prospective rate reporting, incentive tracking, and provider office data exchange. CalOptima implemented the following activities during the measurement period (July 1, 2018, through June 30, 2019): ♦ Implemented the health equity PIP focusing on improving diabetic care for members residing in a geographic region (Santa Ana) and who have poor control (HbA1c>9). ♦ Targeted CalOptima Community Network providers with a high volume of members with poor HbA1c control (>9). Conducted on-site visits with provider offices while providing the following: (1) targeted list of members with HbA1c>9, (2) member detailed data and summary reports, (3) medication review tools, (4) health education and disease management resources, (5) HEDIS quick reference guide, and (6) health coaching counseling services.

2017–18 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	In addition, CalOptima also conducted monthly data exchanges with the offices to obtain updated HbA1c lab data/test results. ♦ Medi-Cal member incentives for HbA1c testing and eye exams. ♦ Member newsletters focusing on diabetes. ♦ Updated the contract with the vision vendor, VSP, to expand vision benefits to members with diabetes to obtain an annual eye exam. ♦ Piloted a data exchange project with one of CalOptima's contracted health networks to obtain data from point-of-care HbA1c testing conducted in-office. CalOptima will expand this program to other health networks once the pilot is successfully completed.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CalOptima's self-reported actions in Table 9.1 and determined that CalOptima adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. CalOptima described in detail actions taken during the review period and steps the MCP plans to take moving forward. HSAG identified the following notable actions taken by the MCP in response to the 2017–18 EQRO recommendations:

- Implemented strategies to address the MCP's declining performance related to the *Asthma Medication Ratio* measure, which may have contributed to the rate for this measure improving significantly from reporting year 2018 to reporting year 2019.
- Expanded on quality improvement efforts begun during the MCP's 2015–17 *Diabetes HbA1c Testing* PIP to support continued improvement on the *Comprehensive Diabetes Care* measures. The MCP reported monthly tracking of the various initiatives.

2018–19 Recommendations

Based on the overall assessment of CalOptima's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to ensure that the MCP fully resolves all findings from the February 2019 Medical and State Supported Services Audits.
- Improve the MCP's processes for how it ensures that the MCP's systems accurately reflect providers' relationships with FQHCs and that the MCP's data mapping accurately reflects the relationships at the provider and FQHC levels. In particular, the MCP should ensure that its data mapping accurately reflects instances for which the FQHC is mapped as a PCP.
- Develop a process to systematically document all data sources and track data volume counts from the point of entry into the MCP's enterprise systems to the point of inputting the data in the measure calculation tool. Additionally, document all data sources in the Roadmap so that the auditor has complete information to review during the approval process.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix I:
Performance Evaluation Report
CalViva Health
July 1, 2018–June 30, 2019

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Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, CalViva Health ("CalViva" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in CalViva's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CalViva is a full-scope MCP delivering services to beneficiaries as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in CalViva, the Local Initiative MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan.

CalViva became operational in Fresno, Kings, and Madera counties to provide MCMC services effective March 2011. As of June 2019, CalViva had 291,316 beneficiaries in Fresno County, 29,326 in Kings County, and 37,002 in Madera County—for a total of 357,644 beneficiaries.[1] This represents 73 percent of the beneficiaries enrolled in Fresno County, 60 percent in Kings County, and 65 percent in Madera County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CalViva. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CalViva. A&I conducted the audits from April 16, 2018, through April 27, 2018.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CalViva
Audit Review Period: April 1, 2017, through March 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	No	No findings.
Member's Rights	No	No findings.
Quality Management	Yes	CAP imposed and findings in this category rectified.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified a finding in only one category (Quality Management) during the April 2018 Medical and State Supported Services Audits of CalViva. CalViva's CAP response regarding the finding in the Quality Management category resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

CalViva has no outstanding findings from the April 2018 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for CalViva Health* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that CalViva followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.27 for CalViva's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.27:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.24 present the performance measure results and findings by domain, and Table 3.25 through Table 3.27 present the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.
- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 through Table 3.3 present the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1 through Table 3.3:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
CalViva—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	68.19%	65.00%	71.28%	69.59%	-1.69
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.29%	94.12%	94.71%	95.11%	0.40

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.89%	85.65%	87.00%	86.27%	-0.73
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.98%	88.19%	**87.34%**	87.81%	0.47
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**86.68%**	**84.96%**	**84.69%**	**85.63%**	0.94
Immunizations for Adolescents—Combination 2	—	27.49%	41.12%	38.69%	-2.43
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	73.71%	71.17%	77.06%	66.67%	-10.39

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	61.18%	60.97%	62.59%	60.00%	-2.59
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.39%	74.43%	81.00%	71.15%	-9.85

Table 3.2—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
CalViva—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**63.03%**	67.71%	66.67%	70.89%	4.22
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**92.49%**	**92.96%**	**92.68%**	94.89%	2.21
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**83.71%**	**83.36%**	85.30%	86.67%	1.37
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**83.31%**	**83.45%**	**82.66%**	**84.96%**	2.30
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**84.21%**	**82.99%**	**82.11%**	**84.54%**	2.43
Immunizations for Adolescents—Combination 2	—	15.33%	30.90%	30.41%	-0.49
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	56.20%	69.83%	74.06%	72.37%	-1.69

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	46.23%	63.26%	67.08%	62.89%	-4.19
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.32%	73.32%	71.65%	73.68%	2.03

Table 3.3—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
CalViva—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	71.19%	72.22%	72.54%	68.06%	-4.48
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	97.28%	96.39%	97.08%	97.21%	0.13
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	91.18%	90.83%	91.65%	91.11%	-0.54
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.71%	90.84%	90.57%	92.07%	1.50
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	90.37%	88.54%	88.56%	89.82%	1.26
Immunizations for Adolescents—Combination 2	—	43.07%	54.74%	53.55%	-1.19
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	82.08%	82.75%	83.23%	85.25%	2.02

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	73.48%	77.49%	79.27%	80.33%	1.06
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	87.08%	86.22%	86.96%	83.57%	-3.39

Table 3.4 through Table 3.6 present findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.4 through Table 3.6:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.4—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CalViva—Fresno County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	5	40.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.5—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CalViva—Kings County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.6—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CalViva—Madera County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	3	5	60.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	4	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.7 through Table 3.9 present the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.7 through Table 3.9:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.7—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
CalViva—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**49.83%**	**51.14%**	**51.12%**	-0.02
Cervical Cancer Screening	61.05%	61.22%	65.82%	59.57%	-6.25
Prenatal and Postpartum Care—Postpartum Care	67.59%	68.03%	68.61%	70.83%	2.22
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.04%	86.89%	88.06%	85.56%	-2.50

Table 3.8—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
CalViva—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	55.21%	55.33%	56.21%	0.88
Cervical Cancer Screening	54.99%	57.95%	65.26%	66.49%	1.23
Prenatal and Postpartum Care—Postpartum Care	**50.24%**	61.07%	59.95%	60.80%	0.85
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.39%	86.37%	86.99%	87.19%	0.20

Table 3.9—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
CalViva—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	58.34%	55.68%	58.05%	2.37
Cervical Cancer Screening	**52.87%**	57.56%	62.78%	63.40%	0.62
Prenatal and Postpartum Care—Postpartum Care	58.76%	64.09%	63.68%	63.54%	-0.14
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.83%	82.29%	85.79%	85.94%	0.15

Table 3.10 through Table 3.12 present findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.10 through Table 3.12:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.10—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CalViva—Fresno County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.11—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CalViva—Kings County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.12—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CalViva—Madera County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Assessment of Improvement Plans—Preventive Screening and Women's Health

Based on reporting year 2018 performance measure results, DHCS required CalViva to submit an IP for the *Breast Cancer Screening* measure in Fresno County. CalViva conducted two PDSA cycles to improve the MCP's performance.

For the first PDSA cycle, CalViva tested whether providing mobile mammography services in the clinic partner's parking lot would increase the number of CalViva beneficiaries who complete a breast cancer screening. For the second PDSA cycle, the MCP modified the intervention to include double and triple appointment booking to maximize utilization of screening at each event.

CalViva reported learning that culture and language are important factors to consider when planning a health screening event. CalViva indicated that to allow the MCP to proactively address potential barriers, it is important to form a multidisciplinary team that includes MCP staff members from cultural and linguistic services, health education, and provider relations departments.

Although CalViva reported reaching each PDSA cycle's SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objective goal, the rate for the *Breast Cancer Screening* measure remained below the minimum performance level in Fresno County in reporting year 2019.

Care for Chronic Conditions

Table 3.13 through Table 3.15 present the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.13 through Table 3.15:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.13 through Table 3.15. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.13—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CalViva—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.94%	85.74%	87.43%	86.89%	-0.54

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.07%	86.24%	87.56%	86.57%	-0.99
*Asthma Medication Ratio^*	—	69.38%	69.83%	63.32%	-6.51
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	**55.72%**	61.31%	66.67%	59.12%	-7.55
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	54.74%	55.96%	56.69%	55.72%	-0.97
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	**36.74%**	46.23%	44.77%	46.72%	1.95
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	**55.47%**	42.34%	45.99%	41.61%	-4.38
*Comprehensive Diabetes Care—HbA1c Testing^*	**80.29%**	84.91%	**83.21%**	**84.43%**	1.22
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	87.83%	90.51%	**87.10%**	89.29%	2.19
Controlling High Blood Pressure	—	—	—	60.34%	Not Comparable

Table 3.14—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CalViva—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**83.07%**	90.43%	89.18%	88.82%	-0.36

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**84.26%**	90.78%	89.54%	89.29%	-0.25
*Asthma Medication Ratio^*	—	66.29%	69.82%	66.58%	-3.24
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	60.34%	65.21%	66.67%	66.42%	-0.25
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	55.96%	54.26%	59.37%	64.72%	5.35
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	42.34%	47.69%	51.58%	51.58%	0.00
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	47.69%	41.85%	35.04%	35.77%	0.73
*Comprehensive Diabetes Care—HbA1c Testing^*	**76.64%**	86.62%	89.05%	91.24%	2.19
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	91.97%	91.97%	90.75%	93.19%	2.44
Controlling High Blood Pressure	—	—	—	62.29%	Not Comparable

Table 3.15—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CalViva—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**83.98%**	**82.64%**	**84.74%**	89.13%	4.39

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**83.57%**	**82.20%**	**84.88%**	90.37%	5.49
*Asthma Medication Ratio^*	—	71.38%	69.98%	66.82%	-3.16
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	65.45%	67.15%	71.29%	77.89%	6.60
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	59.12%	66.42%	62.29%	63.14%	0.85
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	44.28%	49.39%	55.47%	50.61%	-4.86
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	**50.36%**	43.31%	33.33%	40.29%	6.96
*Comprehensive Diabetes Care—HbA1c Testing^*	87.10%	86.62%	88.56%	89.68%	1.12
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	91.73%	90.51%	91.48%	94.84%	3.36
Controlling High Blood Pressure	—	—	—	69.10%	Not Comparable

Table 3.16 through Table 3.18 present findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.16 through Table 3.18:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.16—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CalViva—Fresno County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	2	50.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	9	11.11%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	7	0.00%

Table 3.17—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CalViva—Kings County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Table 3.18—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CalViva—Madera County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	9	22.22%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	9	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	2	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	7	0.00%

Assessment of Improvement Plans—Care for Chronic Conditions

Based on reporting year 2018 performance measure results, DHCS required CalViva to submit IPs for the following measures in Fresno County:

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

DHCS allowed CalViva to combine the MCP's improvement strategies into one IP to address the MCP's performance below the minimum performance levels for both measures. CalViva conducted two PDSA cycles to improve the MCP's performance.

Plan-Do-Study-Act Cycle 1

CalViva tested whether establishing a new panel manager position at a targeted clinic would increase the number of beneficiaries at the clinic with diabetes who complete their testing. The panel manager is a clinician who is responsible for facilitating the completion of appropriate tests and services for key high-risk or problem-prone sub-populations within the total clinic population.

Plan-Do-Study-Act Cycle 2

CalViva modified the intervention tested in the first PDSA cycle to have the panel manager initiate with diabetic beneficiaries a planned care visit, which consisted of using a diabetes call script, Centers for Disease Control and Prevention HEDIS nephropathy workflow, and the targeted clinic planned care visit workflow.

To maximize improvement efforts throughout both PDSA cycles, CalViva health medical management staff members scheduled biweekly meetings to discuss staff successes, challenges, and solutions to barriers. The MCP reported learning that having a clinical champion, such as the panel manager, along with support from the clinic's quality improvement leadership, improves intervention implementation success. Additionally, CalViva

indicated that obtaining staff member feedback is crucial to successful intervention implementation.

CalViva reported reaching each PDSA cycle's SMART objective goal. The rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure improved from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019 in Fresno County. The rate for the *Comprehensive Diabetes Care—HbA1c Testing* measure remained below the minimum performance level in Fresno County in reporting year 2019.

Assessment of Corrective Acton Plan—Care for Chronic Conditions

Based on reporting year 2018 performance measure results, DHCS placed CalViva on a CAP for Madera County. The CAP included both *Annual Monitoring for Patients on Persistent Medications* measures. CalViva conducted two PDSA cycles to improve the MCP's performance on both measures in Madera County.

Plan-Do-Study-Act Cycle 1

CalViva targeted a high-volume clinic and tested whether using standing orders, including mailing lab slips to beneficiaries whom the MCP had been unable to contact via telephone or text messages, would improve beneficiaries' compliance with obtaining needed lab tests. CalViva reported learning that placing standing lab orders and mailing beneficiaries their lab slips enhanced beneficiary outreach, reduced barriers associated with scheduling appointments, and helped streamline the targeted clinic's lab process.

Plan-Do-Study-Act Cycle 2

CalViva tested whether placing an alert in the targeted clinic's scheduling software system for all beneficiaries needing to complete their required lab tests would improve beneficiaries' compliance with obtaining needed lab tests. This intervention supported the clinic in establishing a sustainable method to identify beneficiaries in need of required lab tests, prompted providers to discuss with beneficiaries the need to complete required lab tests, and provided a mechanism for the clinic to track and monitor lab test completion.

CalViva reported reaching each PDSA cycle's SMART objective goal. The rates for both *Annual Monitoring for Patients on Persistent Medications* measures improved significantly from reporting year 2018 to reporting year 2019, and both rates moved from below the minimum performance levels in reporting year 2018 to above the minimum performance levels in reporting year 2019.

Appropriate Treatment and Utilization

Table 3.19 through Table 3.21 present the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.19 through Table 3.21:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.19—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
CalViva—Fresno County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	52.99	51.53	52.57	46.78	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	363.32	341.77	339.01	306.83	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	37.62%	35.34%	31.72%	**25.93%**	-5.79
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	17.20%	Not Comparable
Use of Imaging Studies for Low Back Pain	76.03%	70.65%	74.27%	77.07%	2.80

Table 3.20—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
CalViva—Kings County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	65.99	63.76	60.98	51.23	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	369.80	365.98	370.86	342.06	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	**21.38%**	29.56%	35.29%	30.58%	-4.71
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	13.55%	Not Comparable
Use of Imaging Studies for Low Back Pain	72.87%	75.50%	85.89%	78.02%	-7.87

Table 3.21—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
CalViva—Madera County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	49.44	50.13	49.82	44.00	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	396.51	379.96	353.68	349.65	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	**19.69%**	**18.26%**	**24.58%**	32.55%	7.97
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	13.98%	Not Comparable
Use of Imaging Studies for Low Back Pain	74.17%	**66.67%**	75.64%	79.52%	3.88

Table 3.22 through Table 3.24 present findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.22—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CalViva—Fresno County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	2	50.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	2	50.00%

Table 3.23—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CalViva—Kings County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.24—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CalViva—Madera County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	1	0.00%

Assessment of Corrective Action Plan—Appropriate Treatment and Utilization

Based on reporting year 2018 performance measure results, DHCS placed CalViva on a CAP for Madera County. The CAP included the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure. CalViva conducted two PDSA cycles to improve the MCP's performance on this measure in Madera County.

Plan-Do-Study-Act Cycle 1

CalViva tested whether providing simulation training sessions followed by provider profiling would increase provider compliance with appropriate antibiotic prescribing. CalViva reported learning that active participation in the training sessions by the clinic's chief medical officer and quality improvement lead served as a model for provider behavior change.

Plan-Do-Study-Act Cycle 2

The MCP modified the intervention to have its provider relations staff members navigate the simulations rather than its medical management staff members. CalViva indicated noting that the clinic staff members were sensitive to having the provider relations staff members conduct the simulation exercises since these staff members did not have clinical backgrounds. CalViva reported learning that moving forward, the MCP will need to clearly communicate with the clinic staff members that the purpose of having the public relations staff members conduct the trainings is to demonstrate how to navigate through the simulation.

CalViva indicated that the MCP found the simulation exercise to be a valuable tool for helping providers learn to navigate challenging conversations with their patients about appropriate antibiotic prescribing.

CalViva reported reaching each PDSA cycle's SMART objective goal. The rate for *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure improved from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019 in Madera County.

Performance Measure Findings—All Domains

Table 3.25 through Table 3.27 present a summary of CalViva's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.25 through Table 3.27:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.25—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains CalViva—Fresno County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	3	33.33%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	19	15.79%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	2	19	10.53%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	5	19	26.32%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	16	6.25%

Table 3.26—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
CalViva—Kings County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	19	0.00%

Table 3.27—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains CalViva—Madera County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	5	19	26.32%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	19	15.79%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	3	3	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	16	0.00%

Improvement Plan Requirements for 2019

Based on reporting year 2019 performance measure results, DHCS will require CalViva to continue submitting IPs for the following measures in Fresno County:

- *Breast Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing*

Note that while the rate for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was below the minimum performance level in Fresno County in reporting year 2019, DHCS will not require CalViva to submit an IP for this measure. This is due to DHCS not requiring MCPs to report rates for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure for reporting year 2020.

Corrective Action Plan Requirements for 2019

DHCS issued a CAP closeout letter to CalViva on August 5, 2019. Although DHCS issued the letter outside the review period for this report, HSAG includes the information from the letter because it reflects DHCS' determination that the MCP met all CAP requirements and that the CAP is closed.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.28 through Table 3.30 present the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.31 through Table 3.33 present the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.34 through Table 3.36 present the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.34 through Table 3.36.

Table 3.28—Multi-Year SPD Performance Measure Trend Table
CalViva—Fresno County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	81.25	76.74	77.45	68.87	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	560.97	522.46	533.83	486.32	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.15%	87.62%	88.53%	88.90%	0.37
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.96%	88.20%	90.10%	88.94%	-1.16
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	92.86%	91.67%	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.16%	85.73%	91.35%	92.31%	0.96
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.31%	91.24%	91.66%	92.56%	0.90
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.95%	88.18%	90.21%	88.97%	-1.24
*Plan All-Cause Readmissions***	—	—	—	25.20%	Not Comparable

Table 3.29—Multi-Year SPD Performance Measure Trend Table
CalViva—Kings County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	111.00	111.77	103.12	89.07	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	654.22	629.67	665.82	576.02	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.88%	91.70%	92.47%	88.35%	-4.12
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.82%	95.04%	93.66%	89.93%	-3.73
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.95%	78.08%	84.06%	90.38%	6.32
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	82.69%	88.50%	85.58%	89.32%	3.74
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	86.79%	88.27%	86.47%	87.95%	1.48
*Plan All-Cause Readmissions***	—	—	—	20.61%	Not Comparable

Table 3.30—Multi-Year SPD Performance Measure Trend Table
CalViva—Madera County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	75.78	67.31	67.66	69.77	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	705.32	661.97	629.97	626.03	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.52%	89.79%	87.30%	91.67%	4.37
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.60%	87.69%	88.49%	90.44%	1.95
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	94.23%	91.11%	91.21%	88.41%	-2.80
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	94.69%	97.50%	96.38%	97.12%	0.74
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.10%	86.93%	90.91%	92.00%	1.09
*Plan All-Cause Readmissions***	—	—	—	17.93%	Not Comparable

Table 3.31—Multi-Year Non-SPD Performance Measure Trend Table CalViva—Fresno County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	51.09	50.03	51.16	45.53	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	350.06	331.07	327.97	296.69	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.91%	85.07%	87.07%	86.28%	-0.79
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.06%	85.47%	86.63%	85.73%	-0.90
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.30%	94.13%	94.74%	95.12%	0.38
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.90%	85.65%	86.93%	86.18%	-0.75
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.94%	88.09%	87.21%	87.67%	0.46
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	86.58%	84.84%	84.49%	85.50%	1.01
*Plan All-Cause Readmissions***	—	—	—	13.95%	Not Comparable

Table 3.32—Multi-Year Non-SPD Performance Measure Trend Table CalViva—Kings County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	63.09	60.94	58.61	49.21	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	351.49	350.49	354.28	329.54	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.68%	90.06%	88.26%	88.94%	0.68
Annual Monitoring for Patients on Persistent Medications—Diuretics	83.68%	89.55%	88.39%	89.12%	0.73
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	92.75%	93.11%	92.66%	94.86%	2.20
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.70%	83.48%	85.33%	86.61%	1.28
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	83.33%	83.25%	82.56%	84.82%	2.26
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.05%	82.73%	81.91%	84.41%	2.50
*Plan All-Cause Readmissions***	—	—	—	11.40%	Not Comparable

Table 3.33—Multi-Year Non-SPD Performance Measure Trend Table CalViva—Madera County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	48.14	49.37	49.05	42.97	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	381.28	367.48	341.80	338.56	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.44%	80.99%	84.13%	88.62%	4.49
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.49%	80.68%	83.87%	90.35%	6.48
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	97.26%	96.36%	97.06%	97.20%	0.14
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	91.11%	90.83%	91.66%	91.14%	-0.52
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.62%	90.66%	90.40%	91.92%	1.52
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	90.46%	88.58%	88.49%	89.76%	1.27
*Plan All-Cause Readmissions***	—	—	—	12.95%	Not Comparable

Table 3.34—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CalViva—Fresno County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	68.87	45.53	Not Tested	46.78
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	486.32	296.69	Not Tested	306.83
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.90%	86.28%	2.62	86.89%
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.94%	85.73%	3.21	86.57%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	95.12%	Not Comparable	95.11%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	92.31%	86.18%	6.13	86.27%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	92.56%	87.67%	4.89	87.81%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.97%	85.50%	3.47	85.63%
*Plan All-Cause Readmissions***	25.20%	13.95%	11.25	17.20%

Table 3.35—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CalViva—Kings County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	89.07	49.21	Not Tested	51.23
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	576.02	329.54	Not Tested	342.06
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.35%	88.94%	-0.59	88.82%
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.93%	89.12%	0.81	89.29%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	94.86%	Not Comparable	94.89%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	90.38%	86.61%	3.77	86.67%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.32%	84.82%	4.50	84.96%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.95%	84.41%	3.54	84.54%
*Plan All-Cause Readmissions***	20.61%	11.40%	9.21	13.55%

Table 3.36—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CalViva—Madera County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	69.77	42.97	Not Tested	44.00
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	626.03	338.56	Not Tested	349.65
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.67%	88.62%	3.05	89.13%
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.44%	90.35%	0.09	90.37%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	97.20%	Not Comparable	97.21%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	88.41%	91.14%	-2.73	91.11%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	97.12%	91.92%	5.20	92.07%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	92.00%	89.76%	2.24	89.82%
*Plan All-Cause Readmissions***	17.93%	12.95%	4.98	13.98%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that CalViva stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, CalViva had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019 across all reporting units.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 to reporting year 2019:
  - The reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the following measures:
    - Both *Annual Monitoring for Patients on Persistent Medications* measures in Madera County
    - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Kings and Madera counties
    - *Children and Adolescents' Access to Primary Care Practitioners—12–19Years* in all three counties
  - The reporting year 2019 non-SPD rate was significantly worse than the reporting year 2018 non-SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* measure in Fresno County

- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
    - Both *Annual Monitoring for Patients on Persistent Medications* measures in Fresno County
    - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *12–19 Years* in Fresno County
    - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Fresno and Madera counties
  - The reporting year 2019 SPD rate was significantly worse than the reporting year 2019 non-SPD rate for the *Plan All-Cause Readmissions* measure in Fresno and Kings counties. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that CalViva followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for CalViva:

- The MCP performed the best in Madera County, with this county being the only reporting unit with rates above the high performance levels in reporting year 2019. Across all domains in Madera County, the rates for the following five of 19 measures (26 percent) were above the high performance levels:
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
  - *Immunizations for Adolescents—Combination 2*
  - Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures. Note that the rates for both measures were above the high performance levels for all reporting years displayed in Table 3.3.
- The rates for the following measures improved significantly from reporting year 2018 to reporting year 2019:
  - Both *Annual Monitoring for Patients on Persistent Medications* measures in Madera County, resulting in the rates for both measures moving from below the minimum performance levels in reporting year 2018 to above the minimum performance levels in reporting year 2019.
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in Madera County
  - *Use of Imaging Studies for Low Back Pain* in Fresno County

Opportunities for Improvement—Performance Measures

Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, HSAG identified the following opportunities for improvement for CalViva:

- To improve the MCP's performance to above the minimum performance level for the *Breast Cancer Screening* measure in Fresno County, assess whether the MCP should make changes to its current improvement strategies to address the factors preventing female beneficiaries ages 50 to 74 from getting their mammograms to screen for breast cancer within the appropriate time frame. Note that the MCP's continued performance below the minimum performance level for this measure may be due in part to NCQA's reporting year 2019 specification changes for this measure and therefore may not be related to CalViva's performance.
- To improve the MCP's performance to above the minimum performance level for the *Comprehensive Diabetes Care—HbA1c Testing* measure in Fresno County, assess whether the MCP should make changes to its current strategies to address the factors preventing beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) from receiving their HbA1c tests.
- For the following measures, identify the causes for the significant decline in the MCP's performance from reporting year 2018 to 2019 and as applicable, identify strategies to address the decline in performance:
  - *Asthma Medication Ratio* in Fresno County. Note that the significant decline in the MCP's performance for this measure from reporting year 2018 to reporting year 2019 may be due to NCQA's reporting year 2019 specification changes for this measure and therefore may not be related to CalViva's performance.
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Madera County. Note that the significant decline in the MCP's performance for this measure from reporting year 2018 to reporting year 2019 may be due to NCQA's reporting year 2019 specification changes for this measure and therefore may not be related to CalViva's performance.
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Fresno County.

The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure rate was below the minimum performance level in Fresno County for reporting year 2019. While the MCP has opportunities for improvement related to this measure, HSAG makes no formal recommendations to the MCP because DHCS will not require MCPs to report this measure to DHCS in reporting year 2020, and DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCP's quality improvement actions related to the measure. DHCS and HSAG expect that CalViva will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCP will conduct improvement activities, as applicable, related to this measure.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, CalViva conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's module submissions for both these PIPs as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required CalViva to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, CalViva identified postpartum care in Fresno County as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—CalViva *Postpartum Care* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of postpartum visit completion among beneficiaries at a high-volume, low-compliance clinic in Fresno County.	50%	64%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Postpartum Care* Disparity PIP. Upon initial review of the module, HSAG determined that CalViva met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Supporting the sub-processes selection for the FMEA table.
- Including all required components of the FMEA.

After receiving technical assistance from HSAG, CalViva incorporated HSAG's feedback into Module 3. Upon final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Postpartum Care* Disparity PIP, HSAG reviewed and provided feedback to CalViva on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CalViva that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the interventions that CalViva tested for its *Postpartum Care* Disparity PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

Table 4.2—CalViva *Postpartum Care* Disparity PIP Intervention Testing

Intervention	Key Drivers and/or Failure Modes Addressed
Provide a color-coded postpartum visit alert indicating "schedule postpartum visit 21 to 56 days after delivery" in order to provide staff with the correct time frame at the time this information is needed.	♦ Providers and clinic staff may not be aware of postpartum HEDIS time frames. ♦ Front office staff do not schedule within the correct time frame of 21 to 56 days. ♦ Call center staff do not schedule within the 21-to-56-day time frame.
Revise the obstetric history form to include a question on beneficiaries' cultural preferences.	♦ Existing process does not address cultural issues during the postpartum period.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CalViva to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although CalViva completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CalViva's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required CalViva to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, CalViva selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—CalViva *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of *Childhood Immunization Status—Combination 3* measure compliance among beneficiaries assigned to Health Center A[6] in Fresno County.	48.7%	60.0%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the MCP's *Childhood Immunization Status—Combination 3* PIP. CalViva met all validation criteria for Module 3 in its initial submission. HSAG also reviewed modules 1 and 2 CalViva revised due to one of its provider partners no longer being able to participate in the *Childhood Immunization Status—Combination 3* PIP.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 3* PIP, HSAG reviewed and provided feedback to CalViva on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CalViva that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the interventions that CalViva tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

[6] Health center name removed for confidentiality.

Table 4.4—CalViva *Childhood Immunization Status—Combination 3* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Eliminate the double-booking option for provider scheduling to allow for additional appointment slots for patients to get their needed immunization appointments.	♦ Scheduling process. ♦ Rescheduling/appointment availability/ timing. ♦ Phone system. ♦ Patients wait too long to schedule an appointment.
Provide $25 VISA gift card member incentives for completing immunizations.	♦ Transportation. ♦ Childcare. ♦ Family obligations.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CalViva to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although CalViva completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CalViva's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, CalViva submitted to HSAG all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on CalViva's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with CalViva, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from CalViva's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of CalViva's self-reported actions.

Table 8.1—CalViva's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Through the MCP's CAP, assess whether current improvement efforts should be modified or expanded to improve the MCP's performance to above the minimum performance levels in Madera County for the following measures: a. Both *Annual Monitoring for Patients on Persistent Medications* measures b. *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*	During the 2018–19 intervention period, CalViva reexamined the barriers for measures for which it performed below the minimum performance levels in Madera County: a. Both *Annual Monitoring for Patients on Persistent Medications* measures b. *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* CalViva conducted triannual PDSA cycles in an effort to improve outcomes for both measures. The interventions for *Annual Monitoring for Patients on Persistent Medications* included: ♦ Distribution of care gap reports modified into trackable provider profile tools. ♦ Implementation of text messaging to encourage members to complete their labs and attend their scheduled appointments. ♦ Implementation of a $25 member incentive gift card upon completion of *Annual*

2017–18 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	Monitoring for Patients on Persistent Medications lab tests. ♦ Clinic staff initiated "Lab Concierge" which included escorting members from the medical exam room to the in-home lab department to complete labs. ♦ Clinic implemented standing orders for established patients. ♦ For hard-to-reach patients, standing lab orders were mailed directly to the patients to encourage them to walk in and complete their labs. ♦ Implementation of MedXM, an in-home screening vendor. ♦ The Clinic implemented an "HTN Labs" alert in the clinic's scheduling system to indicate members who need to complete their labs and to create a system for sustaining improvements beyond the life of the improvement team. These interventions were evaluated frequently throughout the year to assess whether the strategies as designed provided the desired improvement based on pre-established goals. Results through June 30, 2019, indicate that these strategies were effective in improving rates to above the minimum performance levels and above the 50th percentiles. The interventions for *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* included the following: ♦ Provider training with a focus on the Robert Wood Johnson Virtual Clinic Simulation at a high-volume low-compliance clinic in Madera County on September 27, 2018. ♦ Active participation of the clinic chief medical officer and quality improvement

2017–18 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	lead in the training sessions served to model provider behavior change. ♦ Obtained current clinic- and provider-specific data for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure and conducted regular multidisciplinary team meetings with the clinic to review and analyze results and initiate timely feedback to providers when indicated, in follow-up to the mandatory training. These interventions were evaluated frequently throughout the year to assess whether the strategies as designed provided the desired improvement based on pre-established goals. Results through June 30, 2019, indicate that these strategies were effective in improving the rate to above the minimum performance level and above the 50th percentile.
2. For the following measures in Fresno County, assess the causes for the MCP's declining performance or performance below the minimum performance levels and identify strategies to improve the MCP's performance: a. *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* b. *Breast Cancer Screening* c. *Comprehensive Diabetes Care—Medical Attention for Nephropathy*	During the 2018–19 intervention period, CalViva worked with the designated improvement teams to examine the barriers for the three measures for which CalViva had declining performance or performance below minimum performance levels in Fresno County: a. *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* b. *Breast Cancer Screening* c. *Comprehensive Diabetes Care—Medical Attention for Nephropathy* CalViva conducted triannual PDSA cycles to implement strategies designed to improve outcomes for all three measures.

2017–18 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	Avoidance of Antibiotic Treatments in Adults With Acute Bronchitis The main barriers identified to contribute to declining rates for the *Avoidance of Antibiotic Treatments in Adults With Acute Bronchitis* measure related to provider/practitioner knowledge of clinical guidelines and patient demand for antibiotics. Strategies for improvement included: ♦ Utilization of the Robert Wood Johnson Foundation Virtual Clinic Simulation at high-volume, low-compliance clinics in Fresno County. The Virtual Clinic simulator assists providers with strategies for managing challenging conversations with patients. This intervention was first successful in Madera County and then expanded to Fresno County with the assistance of provider relations staff members. ♦ Hand delivery of the Alliance Working for Antibiotic Resistance Education (AWARE) toolkits to providers/practitioners in Fresno County. This included mid-level providers who are not included in the distribution of the AWARE toolkits by the California Medical Association. ***Breast Cancer Screening*** A high-volume, low-compliance clinic in Fresno County was selected for this improvement project. Initial analysis of the targeted clinic's data revealed a high volume of Hmong patients and a significant disparity for mammogram completion for this population. Barriers identified for this population included: ♦ Language—many words cannot be translated from English to Hmong, especially medical terms.

2017–18 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	♦ Patients are uncomfortable calling the Imaging Center due to their language barrier even though they may have a referral form. ♦ Non-English patients have encountered difficulty communicating needs to the transportation vendor. ♦ Often the husband or other male family member must approve the individual to have the mammogram. ♦ Patients are afraid they will get cancer from having a mammogram. Strategies for improvement included: ♦ Implementation of mobile mammography at the clinic site. ♦ Implementation of the Member Centered Process: scheduling by clinic staff; member incentive; pre-registration material completed; multiple reminder calls; interpreters on-site to address language and cultural issues; refreshments; and educators with written materials on-site. ♦ Patients were escorted to the mammography coach, and interpreters remained with them as needed during the exam. ♦ A $25 member incentive was provided at the point of service after the mammogram was completed. ***Comprehensive Diabetes Care—Medical Attention for Nephropathy*** Again, a high-volume, low-performing clinic in Fresno County was engaged for quality improvement efforts in this area. Through dialogue with the multidisciplinary team, the following factors were identified to be contributing to declining performance:

2017–18 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	♦ Lack of member engagement—Outreach to these members through telephone and/or mailings from the MCP or the provider are frequently unsuccessful for this population, which needs a higher level of engagement for successful preventive screening and disease management. ♦ Patients often do not understand the actions they should take to manage their chronic diseases. ♦ Annual urinalysis screening for nephropathy is not always ordered by the provider. Strategies for improvement included: ♦ Working with the new panel manager at the targeted clinic to ensure correct tests are ordered for the diabetic patient population. This individual is responsible for improving outcomes for selected populations such as members with diabetes. ♦ Initiating standing orders for routine screening tests such as urinalysis for nephropathy. ♦ Implementing planned care visits with pre-visit patient contact by the panel manager to improve patient engagement and understanding of testing requirements and other actions aimed at disease management.

2017–18 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
3. Assess the causes for the rate for the *Comprehensive Diabetes Care—HbA1c Testing* measure being below the minimum performance level in reporting year 2018 in Fresno County, and apply lessons learned from the MCP's 2015–17 *Diabetes HbA1c Testing* PIP when identifying strategies to improve the MCP's performance.	During the 2018–19 intervention period, CalViva identified several potential barriers common to both the 2015–17 PIP and the current intervention period. These barriers continue to impact the *Comprehensive Diabetes Care—HbA1c Testing* compliance rate. Some of these barriers include: ♦ Lack of member engagement—Outreach to these members through phone and letters from the MCP or the provider is frequently unsuccessful for this population, which needs a higher level of engagement for successful preventive screening and disease management. ♦ Some providers are unclear whether HbA1c testing is a fasting lab. ♦ Labs are not always ordered at the correct intervals. ♦ Care gap reports are not always accurate or correctly reconciled for easy clinic use. Strategies or lessons learned from the 2015–17 *Diabetes HbA1c Testing* PIP that were also implemented during the 2018–19 intervention period included: ♦ Having clinics reconcile the MCP's care gap reports with their own internal records/reports to produce a more real-time list of members who need to close *Comprehensive Diabetes Care* gaps. ♦ Internally reconciling the gap in care list with claims and eligibility data before submitting the list to the clinic. ♦ Conducting member outreach through a variety of methods including telephonic, mail, and texting in order to engage patients in their care.

2017–18 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
4. Continue monitoring adapted and adopted interventions and outcomes to facilitate improvement beyond the life of the 2015–17 *Postpartum Care* and *Diabetes HbA1c Testing* PIPs.	Through our continued PDSA rapid-cycle improvement efforts and new PIP activities, CalViva has continued to monitor both adapted and adopted interventions from the *Postpartum Care* and *Diabetes HbA1c Testing* PIPs of 2015–17. Some of these ongoing interventions include: ♦ Consistently identifying new members/ patients who need preventive services. ♦ Ensuring follow-up on all patients assigned to the clinic (even if they have not been seen in more than 18 months). ♦ Internally reconciling the gap in care list with claims and eligibility data before submitting the list to the clinic. ♦ Working with high-volume, low-compliance clinics to distribute care gap reports to identify patients in need of testing or a visit. ♦ Providing provider education which includes the development and distribution of provider tip sheets on the *Comprehensive Diabetes Care* sub-measures and postpartum visits. ♦ Providing education to both the provider and member that HbA1c labs do not require fasting.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CalViva's self-reported actions in Table 8.1 and determined that CalViva adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. CalViva described in detail actions taken during the review period, lessons learned, and steps the MCP plans to take moving forward. CalViva described specific interventions the MCP implemented to improve performance to above the minimum performance levels or prevent further decline in performance. Some of the MCP's described actions may have contributed to the improvement HSAG noted in Section 3 of this report ("Managed Care Health Plan Performance Measures") under the Strengths—Performance Measures heading.

2018–19 Recommendations

Based on the overall assessment of CalViva's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- To improve the MCP's performance to above the minimum performance levels for the *Breast Cancer Screening* and *Comprehensive Diabetes Care—HbA1c Testing* measures in Fresno County, assess whether the MCP should make changes to its current improvement strategies to address the factors contributing to the MCP's performance below the minimum performance levels.
- For the following measures, identify the causes for the significant decline in the MCP's performance from reporting year 2018 to 2019 and, as applicable, identify strategies to address the decline in performance:
  - *Asthma Medication Ratio* in Fresno County
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Madera County
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Fresno County

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix J:
Performance Evaluation Report
CenCal Health
July 1, 2018–June 30, 2019

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, CenCal Health ("CenCal" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in CenCal's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CenCal is a full-scope MCP delivering services to beneficiaries in the County Organized Health System model.

CenCal became operational to provide MCMC services in Santa Barbara County effective September 1983 and San Luis Obispo County in March 2008. As of June 2019, CenCal had 124,292 beneficiaries in Santa Barbara County and 51,504 in San Luis Obispo County—for a total of 175,796 beneficiaries.[1]

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CenCal. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CenCal. A&I conducted the audits from November 6, 2018, through November 8, 2018.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CenCal
Audit Review Period: November 1, 2017, through October 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	No	No findings.
Member's Rights	Yes	CAP in process and under review.
Quality Management	No	No findings.
Administrative and Organizational Capacity	Yes	CAP in process and under review.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in the Utilization Management, Access and Availability of Care, Quality Management, and State Supported Services categories during the November 2018 Medical and State Supported Services Audits of CenCal.

Opportunities for Improvement—Compliance Reviews

CenCal has the opportunity to work with DHCS to ensure that the MCP fully resolves all findings from the November 2018 A&I Medical and State Supported Services Audits.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for CenCal Health* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that CenCal followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.18 for CenCal's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.18:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.16 present the performance measure results and findings by domain, and Table 3.17 and Table 3.18 present the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.
- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 and Table 3.2 present the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1 and Table 3.2:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
CenCal—San Luis Obispo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	70.25%	69.54%	72.88%	76.72%	3.84
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**94.22%**	95.37%	96.10%	95.71%	-0.39

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.99%	85.97%	88.70%	88.99%	0.29
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.63%	89.86%	91.49%	93.02%	1.53
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.92%	88.58%	89.73%	90.97%	1.24
Immunizations for Adolescents—Combination 2	—	37.38%	46.72%	44.77%	-1.95
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	73.09%	79.69%	86.28%	89.96%	3.68

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	63.21%	73.70%	84.45%	87.34%	2.89
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.46%	69.44%	83.90%	74.58%	-9.32

Table 3.2—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
CenCal—Santa Barbara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	78.46%	77.08%	74.66%	72.27%	-2.39
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.87%	**91.56%**	95.78%	95.73%	-0.05
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	89.86%	**81.00%**	91.12%	91.37%	0.25
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	93.82%	**84.52%**	92.99%	93.35%	0.36
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	90.96%	**79.07%**	90.16%	91.23%	1.07
Immunizations for Adolescents—Combination 2	—	34.43%	46.96%	48.66%	1.70
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	74.86%	80.93%	83.28%	84.35%	1.07

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	62.02%	72.94%	75.82%	80.19%	4.37
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.85%	74.17%	83.49%	80.42%	-3.07

Table 3.3 and Table 3.4 present findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.3 and Table 3.4:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.3—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CenCal—San Luis Obispo County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	5	40.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	4	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.4—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CenCal—Santa Barbara County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	3	5	60.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	4	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.5 and Table 3.6 present the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.5 and Table 3.6:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.5—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
CenCal—San Luis Obispo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	58.10%	62.89%	63.98%	1.09
Cervical Cancer Screening	54.85%	58.68%	64.59%	66.58%	1.99
Prenatal and Postpartum Care—Postpartum Care	64.75%	66.84%	71.16%	69.88%	-1.28
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.61%	92.11%	89.22%	92.11%	2.89

Table 3.6—Preventive Screening and Women's Health Domain Multi-Year Performance Measure Results CenCal—Santa Barbara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	61.00%	62.24%	62.89%	0.65
Cervical Cancer Screening	63.22%	66.41%	61.46%	66.84%	5.38
Prenatal and Postpartum Care—Postpartum Care	76.32%	74.75%	77.57%	79.39%	1.82
Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.72%	93.11%	90.97%	91.89%	0.92

Table 3.7 and Table 3.8 present findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.7 and Table 3.8:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.7—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CenCal—San Luis Obispo County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	3	33.33%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.8—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CenCal—Santa Barbara County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	3	66.67%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.9 and Table 3.10 present the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.9 and Table 3.10:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.9 and Table 3.10. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.9—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CenCal—San Luis Obispo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.48%	**84.29%**	86.60%	**84.63%**	-1.97
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.82%	**83.54%**	**85.17%**	**84.88%**	-0.29
*Asthma Medication Ratio^*	—	69.06%	61.67%	68.01%	6.34
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	68.95%	72.57%	71.39%	72.61%	1.22
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	59.41%	70.57%	72.41%	71.61%	-0.80

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	58.68%	60.85%	59.49%	63.57%	4.08
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	25.92%	28.18%	30.13%	28.64%	-1.49
*Comprehensive Diabetes Care—HbA1c Testing^*	90.71%	88.03%	88.10%	90.20%	2.10
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	89.98%	90.52%	90.13%	90.20%	0.07
Controlling High Blood Pressure	—	—	—	67.40%	Not Comparable

Table 3.10—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CenCal—Santa Barbara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.58%	86.45%	88.16%	**85.15%**	-3.01
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.42%	85.93%	87.47%	86.36%	-1.11
*Asthma Medication Ratio^*	—	72.30%	60.72%	69.22%	8.50
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	70.66%	67.29%	76.82%	67.82%	-9.00
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	71.68%	69.68%	70.57%	71.81%	1.24
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	65.05%	63.03%	65.89%	65.43%	-0.46

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	25.77%	26.33%	25.52%	23.94%	-1.58
*Comprehensive Diabetes Care—HbA1c Testing^*	91.07%	90.43%	91.41%	92.02%	0.61
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	90.82%	88.56%	90.89%	92.82%	1.93
Controlling High Blood Pressure	—	—	—	55.96%	Not Comparable

Table 3.11 and Table 3.12 present findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.11 and Table 3.12:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.11—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CenCal—San Luis Obispo County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	3	9	33.33%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	8	25.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	9	22.22%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	8	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	8	12.50%

Table 3.12—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CenCal—Santa Barbara County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	3	9	33.33%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	3	8	37.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	9	11.11%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	9	11.11%

Assessment of Improvement Plans—Care for Chronic Conditions

Based on reporting year 2018 performance measure results, DHCS required CenCal to submit an IP for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure in San Luis Obispo County.

CenCal conducted two PDSA cycles to test whether using standing orders, along with activating telephonic and written outreach to eligible beneficiaries at a clinic partner, would result in sustainable improvement in annual monitoring for beneficiaries who take diuretics. The MCP reported learning that the standing order process provided structure for efficient follow-up with beneficiaries. Additionally, the intervention outcomes created an opportunity for the clinic to build and improve relationships with its patients.

The rate for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure remained below the minimum performance level in San Luis Obispo County in reporting year 2019.

Appropriate Treatment and Utilization

Table 3.13 and Table 3.14 present the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.13 and Table 3.14:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.

- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.13—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results CenCal—San Luis Obispo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	56.49	57.18	54.06	47.10	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	336.94	325.37	345.93	349.14	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	26.88%	33.48%	36.20%	34.27%	-1.93
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	0.26%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	S	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	13.77%	Not Comparable
Use of Imaging Studies for Low Back Pain	80.43%	69.88%	71.52%	76.36%	4.84

Table 3.14—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results CenCal—Santa Barbara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	50.83	48.72	47.76	42.88	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	296.77	305.58	318.93	323.78	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	28.44%	28.61%	27.10%	31.46%	4.36
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	4.18%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	40.00%	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	13.79%	Not Comparable
Use of Imaging Studies for Low Back Pain	80.81%	73.34%	79.57%	73.18%	-6.39

Table 3.15 and Table 3.16 present findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.15—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CenCal—San Luis Obispo County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.16—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CenCal—Santa Barbara County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.17 and Table 3.18 present a summary of CenCal's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.17 and Table 3.18:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.17—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains CenCal—San Luis Obispo County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	6	19	31.58%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	4	16	25.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	18	5.56%

Table 3.18—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
CenCal—Santa Barbara County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	8	19	42.11%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	6	16	37.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	19	5.26%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	3	19	15.79%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	19	5.26%

Improvement Plan Requirements for 2019

The rates were below the minimum performance levels for the following measures in reporting year 2019:

- Both *Annual Monitoring for Patients on Persistent Medications* measures in San Luis Obispo County
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Santa Barbara County

While CenCal had rates below the minimum performance levels for both *Annual Monitoring for Patients on Persistent Medications* measures in reporting year 2019, DHCS will not require the MCP to submit IPs for these measures due to the small range of variation between the high performance level and minimum performance level thresholds for each measure.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.19 and Table 3.20 present the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.21 and Table 3.22 present the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.23 and Table 3.24 present the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.23 and Table 3.24.

Table 3.19—Multi-Year SPD Performance Measure Trend Table
CenCal—San Luis Obispo County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	96.76	108.28	101.81	83.07	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	618.97	591.41	597.81	595.09	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	92.21%	86.67%	88.46%	88.30%	-0.16
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.91%	88.00%	90.32%	86.56%	-3.76
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	79.80%	84.29%	79.45%	88.46%	9.01
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	83.52%	84.91%	82.88%	87.60%	4.72
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	77.62%	81.66%	82.73%	85.71%	2.98
*Plan All-Cause Readmissions***	—	—	—	21.33%	Not Comparable

Table 3.20—Multi-Year SPD Performance Measure Trend Table
CenCal—Santa Barbara County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	100.61	107.10	92.17	85.69	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	598.50	611.80	627.40	628.41	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.60%	90.43%	90.33%	88.21%	-2.12
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.28%	91.23%	90.48%	88.71%	-1.77
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	93.94%	79.25%	92.73%	93.43%	0.70
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	93.71%	85.67%	92.38%	93.10%	0.72
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	90.62%	79.32%	92.29%	94.22%	1.93
*Plan All-Cause Readmissions***	—	—	—	21.07%	Not Comparable

Table 3.21—Multi-Year Non-SPD Performance Measure Trend Table
CenCal—San Luis Obispo County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	53.77	54.11	51.25	45.07	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	317.85	309.39	331.12	335.23	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.95%	83.63%	86.07%	83.70%	-2.37
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.27%	82.22%	83.71%	84.41%	0.70
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.19%	95.45%	96.07%	95.70%	-0.37
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.12%	86.00%	88.84%	89.00%	0.16
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.87%	90.03%	91.76%	93.17%	1.41
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	89.39%	88.85%	89.99%	91.13%	1.14
*Plan All-Cause Readmissions***	—	—	—	10.87%	Not Comparable

Table 3.22—Multi-Year Non-SPD Performance Measure Trend Table
CenCal—Santa Barbara County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	48.01	45.86	45.70	40.97	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	279.72	290.59	304.63	310.22	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.83%	85.27%	87.55%	84.30%	-3.25
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.76%	84.17%	86.50%	85.65%	-0.85
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.85%	91.55%	95.79%	95.72%	-0.07
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	89.80%	81.02%	91.10%	91.34%	0.24
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	93.82%	84.49%	93.00%	93.35%	0.35
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	90.97%	79.06%	90.11%	91.16%	1.05
*Plan All-Cause Readmissions***	—	—	—	11.13%	Not Comparable

Table 3.23—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CenCal—San Luis Obispo County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	83.07	45.07	Not Tested	47.10
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	595.09	335.23	Not Tested	349.14
Annual Monitoring for Patients on Persistent Medications— ACE Inhibitors or ARBs	88.30%	83.70%	4.60	84.63%
Annual Monitoring for Patients on Persistent Medications— Diuretics	86.56%	84.41%	2.15	84.88%
Children and Adolescents' Access to Primary Care Practitioners— 12–24 Months	NA	95.70%	Not Comparable	95.71%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	88.46%	89.00%	-0.54	88.99%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	87.60%	93.17%	-5.57	93.02%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	85.71%	91.13%	-5.42	90.97%
*Plan All-Cause Readmissions***	21.33%	10.87%	10.46	13.77%

Table 3.24—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CenCal—Santa Barbara County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	85.69	40.97	Not Tested	42.88
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	628.41	310.22	Not Tested	323.78
Annual Monitoring for Patients on Persistent Medications— ACE Inhibitors or ARBs	88.21%	84.30%	3.91	85.15%
Annual Monitoring for Patients on Persistent Medications— Diuretics	88.71%	85.65%	3.06	86.36%
Children and Adolescents' Access to Primary Care Practitioners— 12–24 Months	NA	95.72%	Not Comparable	95.73%
Children and Adolescents' Access to Primary Care Practitioners— 25 Months–6 Years	93.43%	91.34%	2.09	91.37%
Children and Adolescents' Access to Primary Care Practitioners— 7–11 Years	93.10%	93.35%	-0.25	93.35%
Children and Adolescents' Access to Primary Care Practitioners— 12–19 Years	94.22%	91.16%	3.06	91.23%
*Plan All-Cause Readmissions***	21.07%	11.13%	9.94	13.79%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that CenCal stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, CenCal had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019:
  - The reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the following measures:
    - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in San Luis Obispo County.
    - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in both reporting units.
  - The reporting year 2019 non-SPD rate was significantly worse than the reporting year 2018 non-SPD rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure in Santa Barbara County.
- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures in Santa Barbara County:
    - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
    - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
  - The reporting year 2019 SPD rates were significantly worse than the reporting year 2019 non-SPD rates for the following measures:
    - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* in San Luis Obispo County. The significant differences in rates for these measures may be attributed to beneficiaries in these age groups in the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from primary care providers.
    - *Plan All-Cause Readmissions* in both reporting units. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that CenCal followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for CenCal:

- Across both reporting units and domains, 14 of 38 rates (37 percent) were above the high performance levels, with the following 10 rates being above the high performance levels for at least three consecutive years:
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in both reporting units.
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* in both reporting units.
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Santa Barbara County
  - *Prenatal and Postpartum Care—Postpartum Care* in Santa Barbara County.
  - Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures in both reporting units.
- The rates improved significantly from reporting year 2018 to reporting year 2019 for the *Asthma Medication Ratio* measure in both reporting units.

Opportunities for Improvement—Performance Measures

Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, CenCal has the opportunity to determine the causes for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate declining significantly from reporting year 2018 to reporting year 2019 in San Luis Obispo County. To prevent further decline in the rate for this measure in San Luis Obispo County, the MCP should identify strategies to address the causes.

Note that CenCal has opportunities for improvement related to the following measures with rates below the minimum performance levels in reporting year 2019:

- Both *Annual Monitoring for Patients on Persistent Medications* measures in San Luis Obispo County
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Santa Barbara County

While CenCal had rates below the minimum performance levels for both *Annual Monitoring for Patients on Persistent Medications* measures in reporting year 2019, HSAG makes no formal recommendations to the MCP related to these measures due to the small range of variation between the high performance level and minimum performance level thresholds for each measure.

DHCS and HSAG expect that CenCal will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCP will conduct improvement activities, as applicable, related to these two measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, CenCal conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required CenCal to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, CenCal identified completion of the human papillomavirus (HPV) vaccination among adolescents in Santa Barbara County as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—CenCal *HPV Vaccination* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of beneficiaries geographically located in South Santa Barbara County and assigned to Clinic A[6] who receive at least two HPV vaccinations by their 13th birthday	15.00%	48.33%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *HPV Vaccination* Disparity PIP. Upon initial review of the module, HSAG determined that CenCal met some required validation criteria; however, HSAG identified opportunities for improvement related to including a step-by-step flow of the overall process in the process map.

After receiving technical assistance from HSAG, CenCal incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

[6] Clinic name removed for confidentiality.

Intervention Testing

Prior to the intervention testing phase of the MCP's *HPV Vaccination* Disparity PIP, HSAG reviewed and provided feedback to CenCal on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CenCal that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the intervention that CenCal tested for its *HPV Vaccination* Disparity PIP. The table also indicates the key driver and failure mode that the intervention addressed.

Table 4.2—CenCal *HPV Vaccination* Disparity PIP Intervention Testing

Intervention	Key Driver and Failure Mode Addressed
Provide interactive digital education about the importance of HPV immunization via a tablet to all adolescent beneficiaries' guardians in the waiting room/exam room.	♦ Lack of guardians' understanding of the importance of HPV immunization. ♦ Provider clinic not presenting the importance of HPV immunization to the adolescent beneficiaries' guardians at appointments.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CenCal to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although CenCal completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CenCal's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required CenCal to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, CenCal selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—CenCal *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of *Childhood Immunization Status—Combination 3* measure at Provider C[7] in San Luis Obispo County	47.13%	65.25%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the MCP's *Childhood Immunization Status—Combination 3* PIP. Upon initial review of the module, HSAG determined that CenCal met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Describing the priority-ranking process.
- Listing the appropriate potential interventions based on the ranked failure modes.

After receiving technical assistance from HSAG, CenCal incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 3* PIP, HSAG reviewed and provided feedback to CenCal on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CenCal that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

[7] Provider name removed for confidentiality.

Table 4.4 presents a description of the intervention that CenCal tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the key driver and failure mode that the intervention addressed.

Table 4.4—CenCal *Childhood Immunization Status—Combination 3* PIP Intervention Testing

Intervention	Key Driver and Failure Mode Addressed
Assist Provider C in expanding its scheduling system by identifying beneficiaries assigned to Provider C who are due for one or more childhood immunizations and sending an electronic list of these beneficiaries to Provider C. Provider C's call center agents will contact beneficiaries three times telephonically and track whether or not they attend their immunization appointments.	♦ Provider resources. ♦ Pediatric beneficiaries' guardians not making appointments.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CenCal to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although CenCal completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CenCal's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, CenCal submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on CenCal's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[8] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with CenCal, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from CenCal's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of CenCal's self-reported actions.

Table 8.1—CenCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Evaluate the results of the MCP expanding the use of standing orders for lab-monitoring tests and conducting targeted case management for beneficiaries on ACE Inhibitors/ARBs or diuretics, to determine whether or not the intervention is resulting in improved annual monitoring for beneficiaries ages 18 and older who are on diuretics in San Luis Obispo County.	Use of standing orders for lab monitoring tests and conducting targeted case management for beneficiaries on long-term diuretic therapy proved significantly effective in the clinic sites where the intervention was tested. The number of completed lab tests to monitor members on diuretics, however, was not great enough at the intervention sites to improve overall performance in San Luis Obispo County.
2. Assess the causes for the rates in both reporting units declining significantly from reporting year 2017 to reporting year 2018 for the *Asthma Medication Ratio* measure, and identify strategies to prevent the rates for this measure continuing to decline.	CenCal evaluated barriers to use of long-term asthma controller medications and, in response, implemented an automated prescriber alert triggered by a member's ratio of controller medications to total asthma medications. Since the intervention was implemented, performance has improved to 79.5 percent and 79.6 percent in Santa Barbara and San Luis Obispo counties, respectively, to significantly surpass the Medicaid 90th percentile.

2017–18 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
3. Continue monitoring interventions and outcomes to facilitate improvement beyond the life of the 2015–17 *Diabetes Retinal Eye Exam* and *Initial Health Assessment* PIPs.	CenCal is implementing interventions that replicate the highly effective interventions of the 2015–17 *Diabetes Retinal Eye Exam* PIP. CenCal expects that these interventions will demonstrate similar, significant benefits to CenCal's membership. CenCal's initial health assessment pay-for-performance interventions have continued uninterrupted since the 2015–17 PIP to provide a meaningful financial incentive to providers to motivate their completion of timely initial health assessments.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CenCal's self-reported actions in Table 8.1 and determined that CenCal adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. CenCal described actions taken during the review period, including application of lessons learned and steps the MCP plans to take moving forward. HSAG identified the following notable actions taken by the MCP in response to the 2017–18 EQRO recommendations:

- Identified barriers to use of long-term asthma controller medications, and to address these barriers, implemented an automated prescriber alert intervention. The intervention may have contributed to the *Asthma Medication Ratio* measure rates improving significantly from reporting year 2018 to reporting year 2019 in both counties.
- Continued and expanded interventions from the MCP's 2015–17 *Diabetes Retinal Eye Exam* and *Initial Health Assessment* PIPs to sustain successes and improvements from the PIPs.

2018–19 Recommendations

Based on the overall assessment of CenCal's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to ensure that the MCP fully resolves all findings from the November 2018 A&I Medical and State Supported Services Audits.

- Determine the causes for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate declining significantly from reporting year 2018 to reporting year 2019 in San Luis Obispo County and identify strategies to address the causes.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix K:
Performance Evaluation Report
Central California Alliance for Health
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Central California Alliance for Health ("CCAH" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in CCAH's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CCAH is a full-scope MCP delivering services to beneficiaries in the County Organized Health System model.

CCAH became operational to provide MCMC services in Santa Cruz County effective January 1996, in Monterey County effective October 1999, and Merced County effective October 2009. As of June 2019, CCAH had 120,231 beneficiaries in Merced County, 152,496 in Monterey County, and 65,481 in Santa Cruz County—for a total of 338,208 beneficiaries. [1]

DHCS allows CCAH to combine data for Monterey and Santa Cruz counties for reporting purposes. For this report, Monterey and Santa Cruz counties are considered a single reporting unit.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CCAH. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CCAH. A&I conducted the audits from December 3, 2018, through December 7, 2018. During the audits, A&I assessed CCAH's corrective actions related to the findings from the 2017 Medical and State Supported Services Audits. Note that the 2018 audits were limited-scope audits and did not include review of the Case Management and Coordination of Care or Administrative and Organizational Capacity categories.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CCAH
Audit Review Period: November 1, 2017, through October 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Access and Availability of Care	No	No findings.
Member's Rights	No	No findings.
Quality Management	No	No findings.
State Supported Services	No	No findings.

Follow-up on 2017 A&I Medical and State Supported Services Audits

A&I conducted Medical and State Supported Services Audits of CCAH in November 2017, covering the review period of November 1, 2016, through October 31, 2017. HSAG provided a summary of the audit results and status in CCAH's 2017–18 MCP-specific evaluation report. At the time of the 2017–18 MCP-specific evaluation report publication, CCAH's CAP was in progress and under review by DHCS. A letter from DHCS dated September 25, 2018, stated that CCAH provided DHCS with additional information regarding the CAP and that DHCS had reviewed the information and closed the CAP. The letter indicated that DHCS would monitor the MCP's full implementation of the CAP during the subsequent audit.

Strengths—Compliance Reviews

A&I identified no findings during the December 2018 Medical and State Supported Services Audits. Additionally, CCAH fully resolved all outstanding findings from the November 2017 A&I Medical and State Supported Services Audits.

Opportunities for Improvement—Compliance Reviews

CCAH had no findings from the December 2018 A&I Medical and State Supported Services audits and resolved all outstanding findings from the November 2017 audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for Central California Alliance for Health* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that CCAH followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.18 for CCAH's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.18:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.16 present the performance measure results and findings by domain, and Table 3.17 and Table 3.18 present the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.
- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 and Table 3.2 present the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1 and Table 3.2:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
CCAH—Merced County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	68.03%	66.67%	**63.07%**	66.67%	3.60
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.50%	93.96%	95.20%	94.91%	-0.29

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.30%	87.24%	87.85%	88.36%	0.51
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.60%	90.31%	89.38%	90.71%	1.33
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.78%	87.88%	88.01%	89.67%	1.66
Immunizations for Adolescents—Combination 2	—	20.44%	26.52%	27.49%	0.97
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	62.77%	74.45%	77.13%	72.68%	-4.45

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	45.74%	51.82%	64.48%	68.81%	4.33
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.56%	71.34%	70.18%	70.11%	-0.07

Table 3.2—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
CCAH—Monterey/Santa Cruz Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	78.72%	79.86%	79.93%	79.57%	-0.36
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.77%	96.31%	96.48%	96.59%	0.11
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	88.12%	90.32%	90.93%	91.94%	1.01
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.31%	92.30%	93.04%	94.08%	1.04
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.67%	89.02%	89.81%	91.73%	1.92
Immunizations for Adolescents—Combination 2	—	29.20%	44.53%	53.04%	8.51
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	79.52%	88.30%	89.10%	87.20%	-1.90

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	65.43%	74.73%	83.18%	85.60%	2.42
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.46%	82.29%	84.40%	86.46%	2.06

Table 3.3 and Table 3.4 present findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.3 and Table 3.4:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.3—Preventive Screening and Children's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CCAH—Merced County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	4	0.00%

Table 3.4—Preventive Screening and Children's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CCAH—Monterey/Santa Cruz Counties

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	5	5	100.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	3	4	75.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Assessment of Improvement Plans—Preventive Screening and Children's Health

The rate for the *Childhood Immunization Status—Combination 3* measure in Merced County was below the minimum performance level in reporting year 2018; however, because CCAH was already conducting an *Immunizations of Two-Year-Olds* PIP, DHCS did not require the MCP to conduct additional IP activities related to this measure. HSAG includes a summary of CCAH's progress on the *Immunizations of Two-Year-Olds* PIP in Section 4 of this report ("Performance Improvement Projects").

The rate for the *Childhood Immunization Status—Combination 3* measure in Merced County improved to above the minimum performance level in reporting year 2019.

Preventive Screening and Women's Health

Table 3.5 and Table 3.6 present the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.5 and Table 3.6:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.5—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
CCAH—Merced County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	55.84%	54.76%	55.28%	0.52
Cervical Cancer Screening	**51.58%**	56.20%	53.58%	61.22%	7.64
Prenatal and Postpartum Care—Postpartum Care	57.07%	62.77%	60.82%	66.08%	5.26
Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.15%	81.27%	84.79%	83.29%	-1.50

Table 3.6—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
CCAH—Monterey/Santa Cruz Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	61.01%	59.74%	59.97%	0.23
Cervical Cancer Screening	54.79%	54.50%	69.44%	70.90%	1.46
Prenatal and Postpartum Care—Postpartum Care	72.99%	75.52%	81.15%	82.69%	1.54
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.62%	84.78%	85.94%	85.38%	-0.56

Table 3.7 and Table 3.8 present findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.7 and Table 3.8:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.7—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CCAH—Merced County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.8—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CCAH—Monterey/Santa Cruz Counties

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	3	33.33%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.9 and Table 3.10 present the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.9 and Table 3.10:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.9 and Table 3.10. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.9—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CCAH—Merced County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.20%	86.91%	86.56%	87.97%	1.41

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.37%	87.06%	85.85%	87.78%	1.93
*Asthma Medication Ratio^*	—	60.75%	66.21%	64.14%	-2.07
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	59.85%	56.20%	60.34%	67.40%	7.06
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	53.28%	52.80%	60.58%	54.99%	-5.59
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	47.93%	44.04%	50.36%	52.80%	2.44
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	40.63%	44.77%	38.93%	37.23%	-1.70
*Comprehensive Diabetes Care—HbA1c Testing^*	85.64%	88.56%	84.43%	85.16%	0.73
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	89.29%	91.73%	89.78%	88.56%	-1.22
Controlling High Blood Pressure	—	—	—	58.64%	Not Comparable

Table 3.10—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CCAH—Monterey/Santa Cruz Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.93%	86.99%	86.03%	87.84%	1.81

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.64%	87.34%	85.59%	87.76%	2.17
*Asthma Medication Ratio^*	—	70.78%	72.91%	72.08%	-0.83
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	63.75%	63.26%	73.48%	76.28%	2.80
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	60.34%	59.12%	68.37%	63.81%	-4.56
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	53.77%	50.12%	54.99%	51.59%	-3.40
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	38.44%	38.93%	33.33%	36.92%	3.59
*Comprehensive Diabetes Care—HbA1c Testing^*	90.27%	86.86%	89.29%	89.24%	-0.05
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	89.78%	88.81%	88.56%	91.44%	2.88
Controlling High Blood Pressure	—	—	—	61.80%	Not Comparable

Table 3.11 and Table 3.12 present findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.11 and Table 3.12:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.11—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CCAH—Merced County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Table 3.12—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CCAH—Monterey/Santa Cruz Counties

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	9	11.11%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Appropriate Treatment and Utilization

Table 3.13 and Table 3.14 present the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.13 and Table 3.14:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent

services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.

- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.13—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results CCAH—Merced County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	51.37	53.37	53.56	51.81	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	288.32	303.35	316.90	308.74	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	**21.87%**	22.57%	39.40%	40.61%	1.21
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	0.22%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	S	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	17.16%	Not Comparable
Use of Imaging Studies for Low Back Pain	77.09%	70.49%	71.91%	71.56%	-0.35

Table 3.14—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
CCAH—Monterey/Santa Cruz Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	44.44	49.40	47.75	43.70	Not Tested

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	270.16	313.45	317.86	317.14	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	29.24%	37.15%	45.73%	45.25%	-0.48
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	0.28%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	43.10%	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	14.24%	Not Comparable
Use of Imaging Studies for Low Back Pain	84.47%	75.79%	78.35%	76.18%	-2.17

Table 3.15 and Table 3.16 present findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.15—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CCAH—Merced County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.16—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CCAH—Monterey/Santa Cruz Counties

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	2	50.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.17 and Table 3.18 present a summary of CCAH's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.17 and Table 3.18:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.17—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
CCAH—Merced County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	18	0.00%

Table 3.18—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
CCAH—Monterey/Santa Cruz Counties

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	8	19	42.11%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	4	16	25.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	19	15.79%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	19	0.00%

Seniors and Persons with Disabilities Performance Measure Results

Table 3.19 and Table 3.20 present the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.21 and Table 3.22 present the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.23 and Table 3.24 present the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.19—Multi-Year SPD Performance Measure Trend Table CCAH—Merced County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.23 and Table 3.24.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	80.83	91.55	90.12	83.41	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	490.67	515.31	550.60	576.71	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.82%	89.81%	91.68%	90.78%	-0.90
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.79%	91.44%	90.43%	91.13%	0.70
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	89.44%	89.12%	91.01%	91.63%	0.62
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	90.45%	94.70%	93.37%	94.17%	0.80

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	86.10%	86.30%	89.39%	91.99%	2.60
*Plan All-Cause Readmissions***	—	—	—	25.49%	Not Comparable

Table 3.20—Multi-Year SPD Performance Measure Trend Table
CCAH—Monterey/Santa Cruz Counties

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	74.49	85.20	79.17	72.82	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	492.08	575.95	570.07	588.94	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.62%	91.20%	89.98%	90.81%	0.83
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.51%	91.34%	90.53%	90.96%	0.43
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	91.49%	90.24%	96.67%	96.97%	0.30
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	94.34%	94.78%	94.78%	92.90%	-1.88
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	93.18%	95.21%	96.64%	97.95%	1.31

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	90.02%	93.67%	95.42%	94.87%	-0.55
*Plan All-Cause Readmissions***	—	—	—	19.08%	Not Comparable

Table 3.21—Multi-Year Non-SPD Performance Measure Trend Table
CCAH—Merced County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	49.26	50.91	51.30	49.83	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	273.80	289.74	302.44	291.95	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.61%	85.93%	84.80%	86.99%	2.19
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.77%	85.38%	84.10%	86.50%	2.40
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.55%	93.98%	95.17%	94.90%	-0.27
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.25%	87.20%	87.79%	88.29%	0.50
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.57%	90.17%	89.26%	90.60%	1.34

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.86%	87.95%	87.96%	89.58%	1.62
*Plan All-Cause Readmissions***	—	—	—	12.61%	Not Comparable

Table 3.22—Multi-Year Non-SPD Performance Measure Trend Table
CCAH—Monterey/Santa Cruz Counties

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	42.67	47.49	46.12	42.24	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	257.14	299.44	304.82	303.46	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.47%	85.52%	84.72%	86.95%	2.23
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.45%	85.74%	83.65%	86.63%	2.98
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.79%	96.36%	96.48%	96.59%	0.11
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	88.02%	90.25%	90.88%	91.92%	1.04
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.25%	92.23%	92.96%	93.99%	1.03

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.62%	88.90%	89.66%	91.65%	1.99
*Plan All-Cause Readmissions***	—	—	—	12.72%	Not Comparable

Table 3.23—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CCAH—Merced County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	83.41	49.83	Not Tested	51.81
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	576.71	291.95	Not Tested	308.74
Annual Monitoring for Patients on Persistent Medications— ACE Inhibitors or ARBs	90.78%	86.99%	3.79	87.97%
Annual Monitoring for Patients on Persistent Medications— Diuretics	91.13%	86.50%	4.63	87.78%
Children and Adolescents' Access to Primary Care Practitioners— 12–24 Months	NA	94.90%	Not Comparable	94.91%
Children and Adolescents' Access to Primary Care Practitioners— 25 Months–6 Years	91.63%	88.29%	3.34	88.36%
Children and Adolescents' Access to Primary Care Practitioners— 7–11 Years	94.17%	90.60%	3.57	90.71%
Children and Adolescents' Access to Primary Care Practitioners— 12–19 Years	91.99%	89.58%	2.41	89.67%
*Plan All-Cause Readmissions***	25.49%	12.61%	12.88	17.16%

Table 3.24—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CCAH—Monterey/Santa Cruz Counties

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	72.82	42.24	Not Tested	43.70
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	588.94	303.46	Not Tested	317.14
Annual Monitoring for Patients on Persistent Medications— ACE Inhibitors or ARBs	90.81%	86.95%	3.86	87.84%
Annual Monitoring for Patients on Persistent Medications— Diuretics	90.96%	86.63%	4.33	87.76%
Children and Adolescents' Access to Primary Care Practitioners— 12–24 Months	96.97%	96.59%	0.38	96.59%
Children and Adolescents' Access to Primary Care Practitioners— 25 Months–6 Years	92.90%	91.92%	0.98	91.94%
Children and Adolescents' Access to Primary Care Practitioners— 7–11 Years	97.95%	93.99%	3.96	94.08%
Children and Adolescents' Access to Primary Care Practitioners— 12–19 Years	94.87%	91.65%	3.22	91.73%
*Plan All-Cause Readmissions***	19.08%	12.72%	6.36	14.24%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that CCAH stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, CCAH had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the following measures:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in both reporting units
  - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Monterey/Santa Cruz counties
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Monterey/Santa Cruz counties
  - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in both reporting units
  - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in both reporting units
- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
    - Both *Annual Monitoring for Patients on Persistent Medications* measures in both reporting units
    - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* in both reporting units
  - The reporting year 2019 SPD rates were significantly worse than the reporting year 2019 non-SPD rates for the *Plan All-Cause Readmissions* measure in both reporting units. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that CCAH followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for CCAH:

- In Monterey/Santa Cruz counties, across all domains the rates were above the high performance levels for eight of 19 measures (42 percent), with the rates for the following four measures being above the high performance levels for the last three or more consecutive years:
  - *Childhood Immunization Status—Combination 3*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures
- The rate for the *Childhood Immunization Status—Combination 3* measure in Merced County improved from reporting year 2018 to reporting year 2019. Although the improvement was not statistically significant, the change resulted in the rate for this measure moving from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019.
- In Monterey/Santa Cruz counties, the rates for three of 19 measures (16 percent) improved significantly from reporting year 2018 to reporting year 2019. The rate for one measure in Merced County improved significantly from reporting year 2018 to reporting year 2019.

Opportunities for Improvement—Performance Measures

Based on CCAH's reporting year 2019 performance measure results, HSAG has no recommendations for the MCP in the area of performance measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, CCAH conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required CCAH to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, CCAH identified opioid overdose deaths in Merced County as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—CCAH *Opioid Overdose Deaths* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of naloxone (Narcan®) fills among beneficiaries on chronic opioids (opioid fills greater than 30 days within a rolling 12-month period, excluding those with a diagnosis of malignant neoplasm, end stage renal disease, human immunodeficiency virus, transplant, or end-of-life/palliative care) residing in Merced County.	0.07%	4.80%

Intervention Testing

Prior to the intervention testing phase of the MCP's *Opioid Overdose Deaths* Disparity PIP, HSAG reviewed and provided feedback to CCAH on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CCAH that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the intervention that CCAH tested for its *Opioid Overdose Deaths* Disparity PIP. The table also indicates the key drivers and failure modes that the intervention addressed.

Table 4.2—CCAH *Opioid Overdose Deaths* Disparity PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
According to the tenets of academic detailing (NaRCAD), provide customized education and tools, collaboratively develop practice-change actions, and address identified barriers with providers in Merced County who serve the highest number of beneficiaries on chronic opioids.	♦ Appropriate identification of patient opioid overdose risk. ♦ Self-efficacy and intent/motivation of provider to both communicate the need and write a prescription for Narcan. ♦ Provider did not communication the need for Narcan. ♦ Provider was not effective in communicating the need for Narcan.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CCAH to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although CCAH completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CCAH's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required CCAH to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, CCAH selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—CCAH *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of *Childhood Immunization Status—Combination 3* measure for beneficiaries assigned to Provider B.[6]	33.8%	40.0%

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 3* PIP, HSAG reviewed and provided feedback to CCAH on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CCAH that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the interventions that CCAH tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

Table 4.4—CCAH *Childhood Immunization Status—Combination 3* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Provide awareness and support for CCAH's transportation benefits for beneficiaries to use to attend appointments.	♦ Transportation issues.
Provide a monthly report to providers that identifies beneficiaries who need or are past due for immunization services.	♦ Identification of beneficiaries who need (or are past due for) immunization services. ♦ Parents/guardians do not know when vaccines are due and never call or walk into the clinic.

[6] Provider name removed for confidentiality.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CCAH and conducted technical assistance calls with MCP staff members to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although CCAH completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CCAH's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, CCAH submitted to HSAG all required documentation about planned interventions during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on CCAH's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with CCAH, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from CCAH's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of CCAH's self-reported actions.

Table 8.1—CCAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP resolves all deficiencies from the November 2017 A&I Medical and State Supported Services Audits.	The MCP worked with DHCS and engaged in corrective action to resolve all deficiencies from the November 2017 A&I Medical and State Supported Services Audits. DHCS issued a notice on September 25, 2018, stating that the MCP's CAPs for all deficiencies had been accepted and closed.
2. To help improve the MCP's performance to above the minimum performance level in Merced County for the *Childhood Immunization Status—Combination 3* measure: a. Continue monitoring adapted interventions and outcomes to facilitate improvement beyond the life of the 2015–17 *Immunizations of Two-Year-Olds* PIP. b. Apply the lessons learned from the *2015–17 Immunizations of Two-Year-Olds* PIP to the MCP's 2017–19 *Childhood Immunization Status—Combination 3* PIP.	a. HSAG's recommendations have been rolled into the 2017–19 PIP cycle. All intervention activity can be referenced in the respective PIP module submissions. b. Lessons learned and all outcomes have been carried forward into the 2017–19 PIP cycle. Changes and continuances have been adapted as necessary. c. Ongoing evaluation will follow the guidelines of the 2017–19 PIP cycle intervention activities in accordance with the timeline outlined by HSAG. Lessons learned will be applied as necessary and monitored accordingly, and in alignment

2017–18 External Quality Review Recommendations Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
c. Conduct ongoing evaluation of the 2017–19 *Childhood Immunization Status—Combination 3* PIP intervention testing to monitor the effectiveness of the tested intervention(s). Based on evaluation results, the MCP should build on successes and, if needed, make changes in response to lessons learned.	with the appropriate PIP module reporting schedule.
3. Continue monitoring the adapted intervention and outcomes to facilitate improvement beyond the life of the 2015–17 *Improving Health Outcomes of Persons Living With Asthma in Merced County* PIP.	*Asthma Medication Ratio* rates are being monitored in Merced County and have risen from 60.75 percent in first quarter 2018 to 66.21 percent in first quarter 2019. The California Department of Public Health started an Asthma Management Academy which teaches National Asthma Guidelines-based care in a rigorous, encouraging, and skill-building environment. Participants receive technical ongoing assistance, an asthma education toolkit, and a certificate of completion. The PIP provider participants have received training through this program as have other providers in Merced County. This training covers what was offered by CCAH during the PIP. CCAH has focused on other areas such as provider outreach and education according to the National Heart, Lung, and Blood Institute as well as a pharmacy mail order promotion to address the barrier of pharmacy access.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CCAH's self-reported actions in Table 8.1 and determined that CCAH adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. CCAH indicated that the MCP worked with DHCS to fully resolve the deficiencies in the Utilization Management and Member's Rights categories from the November 2017 A&I Medical and State Supported Services Audits. CCAH also summarized actions taken during the review period and stated that the MCP applied lessons learned from the 2015–17 PIPs to the 2017–19 PIPs. Finally, CCAH provided details regarding interventions the MCP is implementing for beneficiaries living with asthma, which may have contributed to the *Asthma Medication Ratio* measure rate in Merced County improving from first quarter 2018 to first quarter 2019.

2018–19 Recommendations

Based on the overall assessment of CCAH's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the MCP.

In the next annual review, HSAG will evaluate continued successes of CCAH.

Appendix L:
Performance Evaluation Report
Community Health Group
Partnership Plan
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Community Health Group Partnership Plan ("CHG" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in CHG's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CHG is a full-scope MCP delivering services to beneficiaries under a Geographic Managed Care (GMC) model. The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

In addition to CHG, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Shield of California Promise Health Plan (known as Care1st Partner Plan prior to January 1, 2019)
- Health Net Community Solutions, Inc.
- Kaiser SoCal
- Molina Healthcare of California Partner Plan, Inc.
- UnitedHealthcare Community Plan

CHG became operational in San Diego County to provide MCMC services effective August 1998. As of June 2019, CHG had 255,691 beneficiaries.[1] This represents 37 percent of the beneficiaries enrolled in San Diego County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CHG. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CHG. A&I conducted the audits from June 25, 2018, through June 27, 2018.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CHG
Audit Review Period: June 1, 2017, through May 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	No	No findings.
Member's Rights	No	No findings.
Quality Management	No	No findings.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings during the June 2018 Medical and State Supported Services Audits of CHG for the MCMC populations subject to this external quality review.

Opportunities for Improvement—Compliance Reviews

A&I identified no findings during the June 2018 A&I Medical and State Supported Services Audits of CHG; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for Community Health Group Partnership Plan* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that CHG followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for CHG's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
CHG—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	66.91%	68.37%	68.86%	80.29%	11.43
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**91.40%**	**93.13%**	93.31%	96.38%	3.07

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**83.16%**	**84.47%**	85.04%	88.72%	3.68
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	88.90%	88.02%	89.73%	92.00%	2.27
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**85.48%**	**84.59%**	86.20%	89.69%	3.49
Immunizations for Adolescents—Combination 2	—	29.20%	31.87%	40.39%	8.52
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	75.67%	80.29%	82.97%	84.18%	1.21

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	76.16%	78.83%	82.00%	80.78%	-1.22
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.32%	71.05%	73.24%	76.89%	3.65

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHG—San Diego County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	3	5	60.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	4	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	5	40.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
CHG—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	64.15%	65.18%	69.54%	4.36
Cervical Cancer Screening	54.78%	55.23%	57.42%	67.40%	9.98
Prenatal and Postpartum Care—Postpartum Care	56.93%	58.15%	66.91%	63.26%	-3.65
Prenatal and Postpartum Care—Timeliness of Prenatal Care	78.83%	79.32%	84.18%	86.13%	1.95

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHG—San Diego County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	3	33.33%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CHG—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.62%	91.28%	90.72%	92.23%	1.51
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.44%	92.01%	91.00%	92.24%	1.24
*Asthma Medication Ratio^*	—	81.98%	64.29%	63.49%	-0.80
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	57.18%	63.50%	76.28%	70.80%	-5.48
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	51.82%	60.34%	66.97%	68.61%	1.64

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	50.61%	59.12%	59.49%	60.83%	1.34
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	38.44%	29.93%	30.29%	25.30%	-4.99
*Comprehensive Diabetes Care—HbA1c Testing^*	89.54%	90.02%	90.69%	92.94%	2.25
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	90.51%	93.67%	93.07%	93.67%	0.60
Controlling High Blood Pressure	—	—	—	72.26%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CHG—San Diego County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	5	9	55.56%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	8	12.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
CHG—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	43.83	42.05	41.47	40.91	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	281.00	274.02	298.87	331.49	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	41.67%	50.74%	61.03%	49.79%	-11.24
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	14.02%	Not Comparable
Use of Imaging Studies for Low Back Pain	**70.98%**	**63.95%**	71.44%	69.30%	-2.14

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CHG—San Diego County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	2	50.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of CHG's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
CHG—San Diego County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	10	19	52.63%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	4	16	25.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	5	19	26.32%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	19	0.00%

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table CHG—San Diego County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.12.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	68.38	72.47	70.92	68.88	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	494.40	544.84	592.05	645.23	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.34%	93.42%	92.58%	94.17%	1.59
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.66%	93.67%	93.19%	94.60%	1.41
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	100.00%	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.56%	90.31%	89.34%	91.91%	2.57
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	87.76%	90.65%	93.41%	96.66%	3.25

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	82.57%	85.08%	86.98%	93.24%	6.26
*Plan All-Cause Readmissions***	—	—	—	19.04%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table CHG—San Diego County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	41.69	39.88	39.44	38.92	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	262.42	254.62	278.71	309.20	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.78%	90.44%	90.01%	91.64%	1.63
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.66%	91.27%	90.08%	91.48%	1.40
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	91.36%	93.11%	93.27%	96.35%	3.08
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.07%	84.34%	84.94%	88.65%	3.71
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	88.94%	87.93%	89.61%	91.83%	2.22

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	85.60%	84.57%	86.18%	89.57%	3.39
*Plan All-Cause Readmissions***	—	—	—	11.57%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CHG—San Diego County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	68.88	38.92	Not Tested	40.91

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	645.23	309.20	Not Tested	331.49
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	94.17%	91.64%	2.53	92.23%
Annual Monitoring for Patients on Persistent Medications—Diuretics	94.60%	91.48%	3.12	92.24%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	100.00%	96.35%	3.65	96.38%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	91.91%	88.65%	3.26	88.72%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	96.66%	91.83%	4.83	92.00%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	93.24%	89.57%	3.67	89.69%
*Plan All-Cause Readmissions***	19.04%	11.57%	7.47	14.02%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that CHG stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 SPD rates were significantly better than the reporting year 2018 SPD rates for the following measures:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
  - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the following measures:
  - Both *Annual Monitoring for Patients on Persistent Medications* measures

  - All four *Children and Adolescents' Access to Primary Care Practitioners* measures
- The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
  - Both *Annual Monitoring for Patients on Persistent Medications* measures
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*
- The reporting year 2019 SPD rate was significantly worse than the reporting year 2019 non-SPD rate for the *Plan All-Cause Readmissions* measure. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that CHG followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for CHG:

- The MCP had no rates below the minimum performance levels.
- Across all domains, CHG performed above the high performance levels for 10 of 19 measures (53 percent), with the rates for the following four measures being above the high performance levels for the last three or more consecutive years:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
  - Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures
- The rates for the following five of 19 measures included in the performance measure analyses (26 percent) improved significantly from reporting year 2018 to reporting year 2019:
  - Both *Annual Monitoring for Patients on Persistent Medications* measures
  - *Breast Cancer Screening*
  - *Childhood Immunization Status—Combination 3*
  - *Immunizations for Adolescents—Combination 2*

Opportunities for Improvement—Performance Measures

Based on CHG's reporting year 2019 performance measure results, HSAG has no recommendations for the MCP in the area of performance measures.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to CHG's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that CHG report rates for three HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for reporting years 2016 through 2019. The reporting year is the year in which the MLTSSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between reporting year 2018 and reporting year 2019. Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of those changes.

Table 4.1—Multi-Year MLTSSP Performance Measure Results
CHG—San Diego County

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	49.17	13.28	44.71	44.53	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	325.92	100.06	353.07	395.40	Not Tested
Medication Reconciliation Post-Discharge	5.60%	5.35%	4.14%	5.35%	1.21

Managed Long-Term Services and Supports Plan Performance Measure Findings

The *Medication Reconciliation Post-Discharge* measure rate showed no statistically significant change from reporting year 2018 to reporting year 2019.

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, CHG conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required CHG to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, CHG identified annual provider visits among male beneficiaries 20 to 30 years of age as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.1—CHG *Annual Provider Visits* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of primary care visits among male beneficiaries 20 to 30 years of age at Clinic A[6]	5.7%	10.0%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Annual Provider Visits* Disparity PIP. Upon initial review of the module, HSAG determined that CHG met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.

After receiving technical assistance from HSAG, CHG incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

[6] Clinic name removed for confidentiality.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Annual Provider Visits* Disparity PIP, HSAG reviewed and provided feedback to CHG on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CHG that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.2 presents a description of the intervention that CHG tested for its *Annual Provider Visits* Disparity PIP. The table also indicates the failure modes that the intervention addressed.

Table 5.2—CHG *Annual Provider Visits* Disparity PIP Intervention Testing

Intervention	Failure Modes Addressed
Research and provide alternative beneficiary phone number(s) to providers.	♦ Many phone numbers provided in the eligibility file are incorrect or not in service. ♦ Incorrect phone numbers hinder establishing care with new beneficiaries.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CHG to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although CHG completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CHG's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required CHG to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, CHG selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.3—CHG *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of *Childhood Immunization Status—Combination 3* measure for Medical Group A[7]	67.1%	79.0%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the MCP's *Childhood Immunization Status—Combination 3* PIP. Upon initial review of the module, HSAG determined that CHG met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Including all required components of the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.

After receiving technical assistance from HSAG, CHG incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 3* PIP, HSAG reviewed and provided feedback to CHG on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CHG that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.4 presents a description of the intervention that CHG tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the failure modes that the intervention addressed.

Table 5.4—CHG *Childhood Immunization Status—Combination 3* PIP Intervention Testing

Intervention	Failure Modes Addressed
Research and provide alternative beneficiary phone number(s) to providers.	♦ Many phone numbers provided in the eligibility file are incorrect or not in service. ♦ Incorrect phone numbers hinder establishing care with new beneficiaries.

[7] Medical group name removed for confidentiality.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CHG to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although CHG completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CHG's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, CHG submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on CHG's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

7. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[8] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

8. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with CHG, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

9. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 9.1 provides EQR recommendations from CHG's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 9.1 to preserve the accuracy of CHG's self-reported actions.

Table 9.1—CHG's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to CHG	Self-Reported Actions Taken by CHG during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Assess the causes for the rates for the following measures declining significantly from RY 2017 to RY 2018, and identify strategies to prevent further decline in performance: a. *Annual Monitoring for Patients on Persistent Medications—Diuretics* b. *Asthma Medication Ratio*	***Annual Monitoring for Patients on Persistent Medications—Diuretics*** The *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure rate was lower by 1.01 percentage point in reporting year 2018 as compared to reporting year 2017. In reporting year 2017, CHG had a bundled pay-for-performance (P4P) incentive which included this measure; however, there was no P4P incentive in reporting year 2018. To prevent further decline, CHG implemented a letter campaign throughout measurement year 2018. Members on persistent diuretics were sent letters to urge them to see their primary care providers to obtain lab tests. ***Asthma Medication Ratio*** The *Asthma Medication Ratio* measure rate was lower by 17.69 percentage points in reporting year 2018 as compared to reporting year 2017. Near the latter half of reporting year 2018, it was discovered that a pharmacy benefits point of sale edit that was

2017–18 External Quality Review Recommendations Directed to CHG	Self-Reported Actions Taken by CHG during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	implemented to change the "refill-too-soon" logic for all prescriptions overrode an edit that was in place to prevent members from receiving more than two albuterol inhalers within a 75-day period without obtaining prior authorization. This increased the amount of albuterol that could be dispensed relative to controller medications. To prevent further decline in the score, the point of sale edits were changed to fire appropriately and as intended. Additionally, CHG's pharmacy team conducted member and provider outreach to address adherence to controller medication.
2. Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2015–17 *Diabetes Retinal Eye Exam* and *Annual Monitoring of Patients on Persistent Medications—ACE Inhibitors or ARBs* PIPs. The MCP should apply lessons learned from both 2015–17 PIPs to facilitate improvement of the adapted interventions.	***Diabetes Retinal Eye Exam*** Based on the results of the PIP, CHG concluded that making timely, reliable gap reports available to primary care sites in a manner that they can easily access and use is key to their success in closing gaps in care. Using the gap reports to conduct outreach activities in collaboration with the vision provider (VSP) has continued to yield positive results. CHG's diabetic retinal exam rates have increased by 1.64 percentage points from reporting year 2018 to reporting year 2019: 66.97 (reporting year 2018) to 68.61 (reporting year 2019). ***Annual Monitoring of Patients on Persistent Medications—ACE Inhibitors or ARBs*** Based on the results of the PIP, CHG concluded that making timely, reliable gap reports available to primary care sites in a manner that they can easily access and use is key to their success in closing gaps in care. Using the gap reports to target outreach activities has continued to yield positive results. CHG's *Annual Monitoring of Patients on Persistent Medications—ACE Inhibitors or ARBs* measure rate increased by 1.51

2017–18 External Quality Review Recommendations Directed to CHG	Self-Reported Actions Taken by CHG during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	percentage points from reporting year 2018 to reporting year 2019: 90.72 (reporting year 2018) and 92.23 (reporting year 2019).

Assessment of MCP's Self-Reported Actions

HSAG reviewed CHG's self-reported actions in Table 9.1 and determined that CHG adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. CHG described actions taken during the review period to assess the causes for the MCP's declining performance on the *Annual Monitoring for Patients on Persistent Medications—Diuretics* and *Asthma Medication Ratio* measures, lessons learned from quality improvement efforts, and steps the MCP plans to take moving forward. Additionally, CHG described how the MCP applied successes from the 2015–17 PIPs to improve performance related to diabetic retinal exams and monitoring beneficiaries taking ACE inhibitors or ARBs.

2018–19 Recommendations

Based on the overall assessment of CHG's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the MCP.

In the next annual review, HSAG will evaluate continued successes of CHG.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix M:
Performance Evaluation Report
Contra Costa Health Plan
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Contra Costa Health Plan ("CCHP" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in CCHP's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

CCHP is a full-scope MCP delivering services to beneficiaries as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in CCHP, the Local Initiative MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan.

CCHP became operational in Contra Costa County to provide MCMC services effective February 1997. As of June 2019, CCHP had 176,519 beneficiaries in Contra Costa County.[1] This represents 87 percent of the beneficiaries enrolled in Contra Costa County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CCHP. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CCHP. A&I conducted the audits from June 4, 2018, through June 15, 2018. As part of the audits, A&I assessed the MCP's implementation of the previous year's CAP and also conducted additional audit steps based on the MCP's utilization management director being indicted on multiple felony charges during the audit period.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CCHP
Audit Review Period: June 1, 2017, through May 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	Yes	CAP in process and under review.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in the Case Management and Coordination of Care, and State Supported Services categories during the June 2018 Medical and State Supported Services Audits of CCHP.

Opportunities for Improvement—Compliance Reviews

CCHP has the opportunity to work with DHCS to ensure that the MCP fully resolves all findings from the June 2018 A&I Medical and State Supported Services Audits. The findings cut across the areas of quality and timeliness of, and access to, health care.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for Contra Costa Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that CCHP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for CCHP's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
CCHP—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	73.97%	76.67%	77.62%	76.16%	-1.46
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.42%	94.00%	93.35%	93.97%	0.62

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**83.56%**	**81.25%**	**83.45%**	85.04%	1.59
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**86.20%**	**84.93%**	**85.55%**	**86.42%**	0.87
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**83.95%**	**80.84%**	**82.42%**	**83.66%**	1.24
Immunizations for Adolescents—Combination 2	—	27.93%	38.44%	46.72%	8.28
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	72.68%	72.93%	80.05%	82.96%	2.91

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	71.58%	71.71%	80.05%	82.59%	2.54
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.14%	71.57%	74.70%	73.83%	-0.87

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CCHP—Contra Costa County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	5	40.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	4	25.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
CCHP—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	58.96%	58.94%	60.10%	1.16
Cervical Cancer Screening	58.15%	58.48%	66.59%	69.00%	2.41
Prenatal and Postpartum Care—Postpartum Care	68.13%	75.43%	70.56%	74.43%	3.87
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.13%	91.24%	86.37%	88.22%	1.85

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CCHP—Contra Costa County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	3	33.33%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
CCHP—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.96%	88.54%	87.74%	88.83%	1.09
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.26%	87.39%	87.70%	88.57%	0.87
*Asthma Medication Ratio^*	—	**46.73%**	**52.52%**	64.45%	11.93
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	60.44%	63.13%	68.47%	77.37%	8.90
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	51.94%	48.74%	61.88%	58.88%	-3.00

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	50.24%	55.56%	48.24%	51.82%	3.58
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	41.50%	31.82%	40.47%	37.71%	-2.76
*Comprehensive Diabetes Care—HbA1c Testing^*	86.17%	90.91%	89.41%	91.73%	2.32
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	88.83%	**88.13%**	**88.47%**	88.81%	0.34
Controlling High Blood Pressure	—	—	—	69.10%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
CCHP—Contra Costa County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	9	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	2	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	7	0.00%

Assessment of Improvement Plans—Care for Chronic Conditions

Based on reporting year 2018 performance measure results, DHCS required CCHP to submit IPs for the following two measures within the Care for Chronic Conditions domain:

- *Asthma Medication Ratio*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Asthma Medication Ratio

CCHP conducted two PDSA cycles to improve the MCP's performance on the *Asthma Medication Ratio* measure.

For the first PDSA cycle, CCHP tested whether distributing gap-in-care lists and educational resources to the clinic partner would result in the clinic staff members contacting beneficiaries regarding asthma medication management.

For the second PDSA cycle, CCHP tested whether implementing a home visiting program aimed at providing education, evaluating environmental triggers, and providing appropriate supplies would lead to beneficiaries becoming compliant with taking their asthma medications.

The *Asthma Medication Ratio* measure rate improved significantly from reporting year 2018 to reporting year 2019, resulting in the rate for this measure moving to above the minimum performance level in reporting year 2019.

Comprehensive Diabetes Care—Medical Attention for Nephropathy

DHCS had previously approved CCHP to conduct a PIP to address the MCP's performance below the minimum performance level for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure; therefore, DHCS did not require the MCP to conduct additional IP activities related to this measure. HSAG includes a summary of CCHP's progress on the *Diabetes Nephropathy Screening* PIP in Section 4 of this report ("Performance Improvement Projects").

The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate moved to above the minimum performance level in reporting year 2019.

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.

- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
CCHP—Contra Costa County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	55.65	53.05	51.47	50.25	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	339.74	287.22	295.57	452.10	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	41.08%	46.60%	46.56%	51.73%	5.17
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	18.39%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	62.06%	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	15.54%	Not Comparable
Use of Imaging Studies for Low Back Pain	82.30%	76.18%	79.57%	79.22%	-0.35

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings CCHP—Contra Costa County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	2	50.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	2	50.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of CCHP's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high

performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:

- *Asthma Medication Ratio*
- *Breast Cancer Screening*
- *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains CCHP—Contra Costa County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	4	19	21.05%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	5	19	26.32%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	2	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	17	0.00%

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table
CCHP—Contra Costa County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.12.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	75.35	75.17	70.18	68.76	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	439.82	434.09	432.60	657.25	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.00%	90.37%	90.15%	90.84%	0.69
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.19%	89.49%	90.35%	91.08%	0.73
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	96.77%	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.65%	85.37%	82.20%	83.89%	1.69
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	85.54%	85.16%	84.17%	85.58%	1.41

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	82.65%	80.22%	80.51%	82.62%	2.11
*Plan All-Cause Readmissions***	—	—	—	19.15%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
CCHP—Contra Costa County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	52.66	49.88	48.70	47.36	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	324.58	266.21	275.31	420.11	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.53%	87.44%	86.26%	87.49%	1.23
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.19%	86.08%	85.98%	86.89%	0.91
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.39%	94.06%	93.38%	94.00%	0.62
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.50%	81.17%	83.48%	85.06%	1.58
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.23%	84.92%	85.60%	86.45%	0.85

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.02%	80.87%	82.52%	83.70%	1.18
*Plan All-Cause Readmissions***	—	—	—	13.11%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CCHP—Contra Costa County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	68.76	47.36	Not Tested	50.25
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	657.25	420.11	Not Tested	452.10
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.84%	87.49%	3.35	88.83%
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.08%	86.89%	4.19	88.57%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	94.00%	Not Comparable	93.97%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.89%	85.06%	-1.17	85.04%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	85.58%	86.45%	-0.87	86.42%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	82.62%	83.70%	-1.08	83.66%
*Plan All-Cause Readmissions***	19.15%	13.11%	6.04	15.54%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that CCHP stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, CCHP had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years,* and *12–19 Years* measures.

- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for both *Annual Monitoring for Patients on Persistent Medications* measures.
  - The reporting year 2019 SPD rate was significantly worse than the reporting year 2019 non-SPD rate for the *Plan All-Cause Readmissions* measure. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that CCHP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for CCHP:

- Across all domains, the rates for four of 19 measures (21 percent) were above the high performance levels, and the rates for five of 19 measures (26 percent) improved significantly from reporting year 2018 to reporting year 2019.
- The following are notable results for specific performance measures:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*. The rate for this measure improved significantly from reporting year 2018 to reporting year 2019.
  - *Asthma Medication Ratio*. The rate for this measure improved significantly from reporting year 2018 to reporting year 2019, resulting in the rate moving to above the minimum performance level.
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*. The rate for this measure improved significantly from reporting year 2018 to reporting year 2019 and was above the high performance level for all reporting years displayed in Table 3.7.
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*. The rate for this measure improved significantly from reporting year 2018 to reporting year 2019.
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*. The rate for this measure improved from reporting year 2018 to reporting year 2019. Although the improvement was not statistically significant, the change resulted in the rate for this measure moving from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019.
  - *Immunizations for Adolescents—Combination 2*. The rate for this measure improved significantly from reporting year 2018 to reporting year 2019 and was above the high performance level.
  - *Prenatal and Postpartum Care—Postpartum Care*. The rate for this measure was above the high performance level in reporting year 2019.

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total*. The rate for this measure was above the high performance level for all reporting years displayed in Table 3.1.

Opportunities for Improvement—Performance Measures

Based on CCHP's reporting year 2019 performance measure results, HSAG has no recommendations for the MCP in the area of performance measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, CCHP conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required CCHP to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, CCHP identified controlling blood pressure among African-American beneficiaries as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—CCHP *Controlling Blood Pressure* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of hypertension control among African-American beneficiaries ages 18 to 85 who receive care at Clinic A[6]	61.40%	66.58%

Intervention Testing

Prior to the intervention testing phase of the MCP's *Controlling Blood Pressure* Disparity PIP, HSAG reviewed and provided feedback to CCHP on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CCHP that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the interventions that CCHP tested for its *Controlling Blood Pressure* Disparity PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

[6] Clinic name removed for confidentiality.

Table 4.2—CCHP *Controlling Blood Pressure* Disparity PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Pilot a reminder call program for beneficiaries who are overdue for primary care provider (PCP) appointments.	♦ Engaging beneficiaries who have not been seen for routine care. ♦ No routine follow-up done on beneficiaries who are overdue for, miss, or cancel appointments.
Work with providers and case managers to outreach to beneficiaries with uncontrolled hypertension and offer a home visit with a community health worker to provide blood pressure management education and administer an Omron blood pressure cuff for beneficiaries to check their own blood pressure.	♦ Social and environmental factors that impact blood pressure control.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CCHP and conducted technical assistance calls with the MCP staff members to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although CCHP completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in CCHP's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required CCHP to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, CCHP selected nephropathy screening among beneficiaries living with diabetes as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—CCHP *Diabetes Nephropathy Screening* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of nephropathy screening among beneficiaries ages 18 to 75 with a diagnosis of diabetes who reside in Contra Costa County and receive care at Health Center[7]	77.78%	91.97%

Intervention Testing

Prior to the intervention testing phase of the MCP's *Diabetes Nephropathy Screening* PIP, HSAG reviewed and provided feedback to CCHP on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to CCHP that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the interventions that CCHP tested for its *Diabetes Nephropathy Screening* PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

Table 4.4—CCHP *Diabetes Nephropathy Screening* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Offering an in-home testing option for nephropathy screening.	♦ Tailored education about the importance of nephropathy testing. ♦ Avoid lab wait times. ♦ Resolve transportation concerns.
Emailing PCPs a list of their patients who are overdue for nephropathy screening.	♦ Lack of follow-up for missed doctor and lab visits.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to CCHP and conducted technical assistance calls with MCP staff members to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although CCHP completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no

[7] Health center name removed for confidentiality.

outcomes information in this report. HSAG will include a summary of the PIP outcomes in CCHP's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, CCHP submitted to HSAG all required documentation about planned interventions during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on CCHP's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[8] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with CCHP, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from CCHP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of CCHP's self-reported actions.

Table 8.1—CCHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Identify strategies to address the MCP's performance below the minimum performance level for the *Asthma Medication Ratio* measure. During the process of identifying strategies, apply lessons learned, as applicable, from the MCP's 2015–17 *Medication Management for People With Asthma* PIP; and spread successful strategies that contributed to the rate for this measure improving significantly from RY 2017 to RY 2018.	We continued existing interventions, including providing pediatricians with lists of their patients with bad asthma medication ratios. We also began to pilot an asthma home visiting program. The HEDIS 2019 rate increased by 12 percentage points and is well above the minimum performance level.
2. To support the MCP's efforts to improve performance to above the minimum performance level for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure, ensure that the MCP incorporates HSAG's initial feedback on the Plan portion of Module 4 prior to testing the in-home nephropathy screening intervention for the MCP's *Diabetes Nephropathy Screening* PIP.	We were unable to institute the in-home testing program due to contracting issues and DHCS rules. Instead, we performed provider education on the measure and what makes the measure compliant. We found this education successful and will continue this effort. The spread between minimum performance level and high performance level is only five percentage points. We were surprised to be below the minimum performance level when

2017–18 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
Additionally, the MCP should monitor the intervention effectiveness measure throughout the intervention testing phase and take appropriate actions (i.e., adopt, adapt, or abandon) based on intervention testing results. If CCHP determines the tested intervention to be successful, the MCP should expand the intervention in multiple environments.	we had been above the high performance level for several years. Happily, the rate has gone back to above the minimum performance level.
3. Assess the causes for the MCP's performance declining significantly from RY 2017 to RY 2018 for the following measures; and identify strategies to prevent the MCP's performance from continuing to decline: a. *All-Cause Readmissions* b. *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* c. *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* *d. Prenatal and Postpartum Care—Timeliness of Prenatal Care*	***All-Cause Readmissions*** The increase stemmed from an increase in SPD's readmissions. We had lost the registered nurse who had conducted rounds with our members in skilled nursing facilities. To improve, we started joint operations meetings with local hospitals. ***Comprehensive Diabetes Care*** We believe that the drop in HbA1c control scores was actually due to missing data. We conducted provider education and continued our diabetes support program. The HbA1c scores have since improved. ***Timeliness of Prenatal Care*** We looked at strategies for improving prenatal care scores but were unable to implement any. The score went back up for reporting year 2019.
4. Continue monitoring interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2015–17 *Postpartum Care* PIP.	We have continued interventions, and our *Prenatal and Postpartum Care—Postpartum Care* measure rate is above the 90th percentile.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CCHP's self-reported actions in Table 8.1 and determined that CCHP adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. CCHP described actions taken during the review period, results from the MCP's assessment of declining performance, and steps the MCP plans to take moving forward. HSAG identified the following notable actions taken by the MCP in response to the 2017–18 EQRO recommendations:

- Piloted an asthma home visiting program and noted that the rate for the *Asthma Medication Ratio* measure improved by 12 percentage points, moving the rate to above the minimum performance level in reporting year 2019.
- Identified a new provider education intervention to test for the *Diabetes Nephropathy Screening* PIP and determined this intervention was successful, resulting in the MCP continuing the effort.
- Continued interventions started during the 2015–17 *Postpartum Care* PIP and noted that the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure was above the high performance level in reporting year 2019.

2018–19 Recommendations

Based on the overall assessment of CCHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that CCHP work with DHCS to ensure that the MCP fully resolves all findings from the June 2018 A&I Medical and State Supported Services Audits.

In the next annual review, HSAG will evaluate continued successes of CCHP as well as the MCP's progress with this recommendation.

Appendix N:
Performance Evaluation Report
Family Mosaic Project
July 1, 2018–June 30, 2019

Table of Contents

Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted SHP, Family Mosaic Project ("FMP" or "the SHP"). The purpose of this appendix is to provide SHP-specific results of each activity and an assessment of the SHP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this SHP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in FMP's 2019–20 SHP-specific evaluation report. This SHP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Specialty Health Plan Overview

FMP is an SHP which provides intensive case management and wraparound services for MCMC children and adolescents at risk of out-of-home placement in San Francisco County. FMP is part of the Child, Youth, and Family System of Care operated by the City and County of San Francisco Department of Public Health (SFDPH) Community Behavioral Health Services. To receive services from FMP, a beneficiary must meet specific enrollment criteria, including being a San Francisco resident between 3 and 18 years of age, having serious mental health care needs, and being at imminent risk of (or already in) out-of-home placement. FMP submits qualifying clients to DHCS for approval to be enrolled in FMP's MCMC. Once a client is approved and included under FMP's contract with DHCS, the SHP receives a per-beneficiary, per-month capitated rate to provide mental health and related wraparound services. Due to FMP's unique membership, some SHP contract requirements differ from the MCP contract requirements.

FMP became operational in San Francisco County to provide MCMC services effective December 1992. As of June 2019, FMP had 29 beneficiaries.[1]

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Specialty Health Plan Compliance

Compliance Reviews Conducted

DHCS' Mental Health Services Division (MHSD) conducts triennial oversight reviews of each county mental health plan (MHP) to determine compliance with federal and State regulations as well as with the terms of the MHP contract. DHCS works closely with each MHP to ensure compliance and to identify opportunities for improvement. Using a collaborative and educational approach, DHCS provides guidance and technical assistance when DHCS determines that the MHP is out of compliance. After the review, DHCS identifies strength-based practices of the MHP and provides feedback related to areas of non-compliance. DHCS provides the MHP with a written report of findings which includes a description of each finding, a description of any corrective action(s) needed, and the time frames in which the MHP is required to become compliant. For all items that DHCS determines to be out of compliance, MHPs are required to submit a plan of correction to DHCS within 60 days of the MHP's receipt of the final report of findings. If an urgent issue is identified, the issue is addressed immediately.

DHCS did not conduct an oversight review of FMP directly during the review period for this report. The most recent review conducted by DHCS was a triennial on-site review of the San Francisco County MHP from April 24, 2017, through April 27, 2017. FMP is part of the Child, Youth, and Family System of Care operated by the San Francisco Department of Public Health Community Behavioral Health Services; therefore, FMP was included in the April 24, 2017, review. HSAG included a summary of the April 2017 review in FMP's 2016–17 SHP-specific evaluation report.

3. Specialty Health Plan Performance Measures

Performance Measure Validation Results

For reporting year 2019, FMP was required to report two performance measures—*Promotion of Positive Pro-Social Activity* and *School Attendance*. Neither measure is a HEDIS®[2] measure; therefore, HSAG conducted performance measure validation for the two performance measures selected, calculated, and reported by the SHP. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services' (CMS') publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[3] (i.e., CMS' performance measure validation protocol).

The *2019 Validation of Performance Measures Final Report of Findings for Family Mosaic Project* contains the detailed findings and recommendations from HSAG's performance measure validation of the two measures that FMP reported. The HSAG auditor determined that FMP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results

After validating the SHP's performance measure rates, HSAG assessed the results. See Table 3.1 for FMP's performance measure results for reporting years 2018 and 2019. The reporting year is the year in which the SHP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that while FMP reported rates for the *Promotion of Positive Pro-Social Activity* and *School Attendance* measures prior to reporting year 2018, because of specification changes made to both measures in reporting year 2018, the measures were considered first-year measures in reporting year 2018. Note that FMP had less than 30 beneficiaries during reporting years 2018 and 2019, resulting in an "NA" audit designation for each performance measure.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf. Accessed on: Nov 26, 2019.

Table 3.1—Multi-Year Performance Measure Results
FMP—San Francisco County

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
School Attendance	NA	NA	Not Comparable
Promotion of Positive Pro-Social Activity	NA	NA	Not Comparable

Strengths—Performance Measures

The HSAG auditor determined that FMP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Opportunities for Improvement—Performance Measures

Based on performance measure results, HSAG has no recommendations for FMP in the area of performance measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, FMP conducted two SHP-specific PIPs. In this report, HSAG includes summaries of the SHP's PIP module submissions as well as validation findings from the review period.

Reducing Physical Health Issues Performance Improvement Project

FMP selected reduction of physical health issues as one of its 2017–19 PIP topics based on its SHP-specific data.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—FMP *Reducing Physical Health Issues* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of beneficiaries ages 0 to 18 years who score 0 or 1 on the Physical/Medical rating, which evaluates beneficiaries' health problems and chronic/acute conditions.	83%	90%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated modules 1 through 3 for the SHP's *Reducing Physical Health Issues* PIP. Upon initial review of the modules, HSAG determined that FMP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Supporting the topic selection with the SHP's data.
- Identifying appropriate team members that include both internal staff and external partners.
- Including all required components of the:
  - SMART Aim, developed based on literature review, data, and/or experience.
  - SMART Aim measure.
  - SMART Aim data collection methodology.
  - Run/control chart.
- Aligning accurately the Global Aim, SMART Aim, key drivers, and potential interventions.
- Including a step-by-step flow of the overall process in the process map.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, FMP incorporated HSAG's feedback into modules 1 through 3. Upon HSAG's final review, HSAG determined that the SHP met all validation criteria for modules 1 through 3.

Intervention Testing

Prior to the intervention testing phase of the SHP's *Reducing Physical Health Issues* PIP, HSAG reviewed and provided feedback to FMP on the Plan portion of the PDSA cycle for the intervention that the SHP selected to test. HSAG indicated to FMP that the SHP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the intervention that FMP tested for its *Reducing Physical Health Issues* PIP. The table also indicates the key drivers that the intervention addressed.

Table 4.2—FMP *Reducing Physical Health Issues* PIP Intervention Testing

Intervention	Key Drivers Addressed
Have a psychiatrist provide psychoeducation to beneficiaries with physical health concerns and serve as a liaison between beneficiaries and the primary care team.	♦ Identification of beneficiaries who have significant health issues. ♦ Beneficiaries' and caregivers' initial access/linkage to health care resources (clinics, providers, and treatment) for physical health issues.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to FMP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although FMP completed testing the intervention through the SMART Aim end date of June 30, 2019, the SHP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this SHP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in FMP's 2019–20 SHP-specific evaluation report.

Improving Client Access and Use of Recreational Activities Performance Improvement Project

FMP selected improving client access and use of recreational activities as one of its 2017–19 PIP topics based on its SHP-specific data.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—FMP *Improving Client Access and Use of Recreational Activities* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of beneficiaries ages 0 to 18 years who score 0 or 1 on the Recreational rating, which reflects beneficiaries' access to and use of leisure time activities.	50%	70%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 1 through 3 for the SHP's *Improving Client Access and Use of Recreational Activities* PIP. Upon initial review of the modules, HSAG determined that FMP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Supporting the topic selection with the SHP's data.
- Identifying appropriate team members that include both internal staff and external partners.
- Including all required components of the:
  - SMART Aim, developed based on literature review, data, and/or experience.
  - SMART Aim measure.
  - SMART Aim data collection methodology.
  - Run/control chart.
- Aligning accurately the Global Aim, SMART Aim, key drivers, and potential interventions.
- Including a step-by-step flow of the overall process in the process map.
- Considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, FMP incorporated HSAG's feedback into modules 1 through 3. Upon HSAG's final review, HSAG determined that the SHP met all validation criteria for modules 1 through 3.

Intervention Testing

Prior to the intervention testing phase of the SHP's *Improving Client Access and Use of Recreational Activities* PIP, HSAG reviewed and provided feedback to FMP on the Plan portion of the PDSA cycle for the intervention that the SHP selected to test. HSAG indicated to FMP that the SHP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the intervention that FMP tested for its *Improving Client Access and Use of Recreational Activities* PIP. The table also indicates the key drivers that the intervention addressed.

Table 4.4—FMP *Improving Client Access and Use of Recreational Activities* PIP Intervention Testing

Intervention	Key Drivers Addressed
Have a member of the behavioral support team accompany beneficiaries to the first three sessions of recreational activity.	♦ Identification of beneficiaries who have limited access or engagement in recreational activities. ♦ Beneficiaries' and caregivers' initial identification/linkage to potential recreational activities for beneficiaries.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to FMP to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although FMP completed testing the intervention through the SMART Aim end date of June 30, 2019, the SHP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this SHP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in FMP's 2019–20 SHP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, FMP submitted all required documentation and met all criteria for PIP modules that the SHP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on FMP's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Consumer Surveys

DHCS periodically evaluates the perceptions and experiences of beneficiaries as part of its process for assessing the quality of health care services. For full-scope MCPs, DHCS contracted with HSAG during the July 1, 2018, through June 30, 2019, reporting period to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[4] survey instruments.

SHPs are not included in the CAHPS surveys that HSAG conducts and are instead required to administer their own annual consumer surveys to evaluate beneficiary experience regarding care and services provided.

While HSAG reviewed the information submitted by FMP to DHCS for the consumer surveys conducted during the review period of this report, the purpose of HSAG's review was to confirm the SHP conducted the survey as required, not to analyze the survey results or identify opportunities for improvement. The following is a brief summary of the consumer surveys conducted for FMP, including the notable high-level results.

Consumer Surveys Conducted for Family Mosaic Project

During a designated week twice each year, FMP concurrently administers two surveys to its youth beneficiaries and their families: the Youth Services Survey and Youth Services Survey for Families. During the review period for this report, FMP conducted these surveys in fall 2018 (from November 5, 2018, through November 9, 2018) and spring 2019 (from May 13, 2019, through May 17, 2019). The surveys included 26 items designed to assess satisfaction with various aspects of FMP services and the respondents' perceptions of the effects of the services on their lives. The survey items were rated on a 5-point Likert scale, and surveys with a mean score of 3.5 or higher were counted as "satisfied."

Results—Consumer Surveys

Fall 2018 Results

FMP administered the surveys to 32 youth beneficiaries and their family members during the November 5, 2018, through November 9, 2018 survey period, of which 28 (87.5 percent) completed the survey with an overall satisfaction rate of 96.4 percent.

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

The following three satisfaction items were rated the highest by respondents:

- I helped to choose my treatment goals—96.4 percent
- I participated in my own treatment—96.4 percent
- Staff treated me with respect—96.4 percent

The following three satisfaction items were rated the lowest by respondents:

- I felt I had someone to talk to when I was troubled—85.2 percent
- The people helping me stuck with me no matter what—85.7 percent
- I got as much help as I needed—88.5 percent

Spring 2019 Results

FMP administered the surveys to 23 youth beneficiaries and their family members during the May 13, 2019, through May 17, 2019, survey period, of which 20 (87.0 percent) completed the survey with an overall satisfaction rate of 90.0 percent.

The following three satisfaction items were rated the highest by respondents:

- I got the help I wanted—100.0 percent
- Staff treated me with respect—100.0 percent
- Staff spoke with me in a way that I understood—100.0 percent

The following three satisfaction items were rated the lowest by respondents:

- I helped to choose my services—80.0 percent
- Services were available at times that were convenient for me—89.5 percent
- I helped to choose my treatment goals—90.0 percent

When comparing the satisfaction items from the fall 2018 and spring 2019 surveys, the “Staff treated me with respect” satisfaction item was rated highest by respondents in both surveys.

FMP indicated that it uses the survey results to identify PIP topics.

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 6.1 provides EQR recommendations from FMP's July 1, 2017, through June 30, 2018, SHP-specific evaluation report, along with the SHP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of FMP's self-reported actions.

Table 6.1—FMP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, SHP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to FMP	Self-Reported Actions Taken by FMP during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2015–17 *Ensuring Primary Care Connections* PIP, and incorporate lessons learned from this PIP to improve the effectiveness of the adopted intervention.	We continue to track both the quantitative data and the qualitative data collected. As stated in the data collection procedure, our quantitative data are collected in AVATAR and, as part of our regular quality assurance process, various data points are tracked quarterly. We also developed another PIP to further develop our goal to connect clients to primary care in a more consistent and meaningful way. One barrier during this period has been the ability to hire a nurse.
2. Apply the lessons learned from the 2015–17 *Promoting Caregiver Engagement and Participation* PIP to facilitate improvement for future PIPs.	An important factor brought out in the qualitative data also pointed to the importance of understanding and addressing caretaker mental health and substance use issues, which are prevalent in our target families. We have identified certain staff members to receive evidenced-based practice training in these specific areas in order to best work with caretakers.

Assessment of SHP's Self-Reported Actions

HSAG reviewed FMP's self-reported actions in Table 6.1 and determined that FMP adequately addressed HSAG's recommendations from the SHP's July 1, 2017, through June 30, 2018, SHP-specific evaluation report. FMP indicated that the SHP continued to track both quantitative and qualitative data related to the 2015–17 *Ensuring Primary Care Connections* PIP, and that the SHP had developed another PIP to further develop its goal to connect clients to primary care in a more consistent and meaningful way. Additionally, FMP indicated that a lesson learned from the 2015–17 *Promoting Caregiver Engagement and Participation* PIP led to the SHP having some of its staff members receive training in the areas of understanding and addressing caretaker mental health and substance use issues.

2018–19 Recommendations

Based on the overall assessment of FMP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the SHP.

In the next annual review, HSAG will evaluate continued successes of FMP.

Appendix O:
Performance Evaluation Report
Gold Coast Health Plan
July 1, 2018–June 30, 2019

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Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Gold Coast Health Plan ("Gold Coast" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in Gold Coast's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Gold Coast is a full-scope MCP delivering services to beneficiaries in the County Organized Health System model.

Gold Coast became operational to provide MCMC services in Ventura County effective July 2011. As of June 2019, Gold Coast had 195,006 beneficiaries.[1]

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Gold Coast. The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Gold Coast. A&I conducted the audits from June 4, 2018, through June 14, 2018.

Note that while A&I conducted the audits outside the review period for this MCP-specific evaluation report, HSAG includes the audit results and status because the reports were issued on September 28, 2018, which is within the review period. Additionally, while the closeout letter was issued on July 10, 2019, which is outside the review period for this MCP-specific evaluation report, HSAG includes the information from the letter because the letter reflects full resolution of all findings from the June 2018 A&I Medical Audit.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Gold Coast Audit Review Period: April 1, 2017, through March 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	No	No findings.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	No	No findings.
Administrative and Organizational Capacity	Yes	CAP imposed and findings in this category rectified.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

During the June 2018 Medical and State Supported Services Audits of Gold Coast, A&I identified no findings in the following categories:

- Utilization Management
- Case Management and Coordination of Care
- Access and Availability of Care
- Quality Management
- State Supported Services

Gold Coast's CAP response regarding the findings in the Member's Rights and Administrative and Organizational Capacity categories resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

Gold Coast has no outstanding findings from the June 2018 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for Gold Coast Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that Gold Coast followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for Gold Coast's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Gold Coast—Ventura County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	75.43%	64.96%	70.53%	75.67%	5.14
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.65%	93.86%	95.05%	94.43%	-0.62

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**84.87%**	85.52%	**84.72%**	86.82%	2.10
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**85.62%**	**84.54%**	**86.12%**	87.74%	1.62
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**84.14%**	**82.32%**	**83.69%**	**85.17%**	1.48
Immunizations for Adolescents—Combination 2	—	23.11%	33.58%	34.06%	0.48
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	55.96%	54.50%	79.56%	80.59%	1.03

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	49.88%	48.66%	74.94%	77.39%	2.45
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**64.72%**	66.18%	75.47%	74.73%	-0.74

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Gold Coast—Ventura County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Gold Coast—Ventura County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	59.34%	59.01%	60.78%	1.77
Cervical Cancer Screening	**50.61%**	54.50%	57.46%	56.08%	-1.38
Prenatal and Postpartum Care—Postpartum Care	59.12%	65.45%	68.35%	77.39%	9.04
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.24%	84.18%	82.45%	86.17%	3.72

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Gold Coast—Ventura County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	3	33.33%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	3	66.67%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Gold Coast—Ventura County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.94%	**85.09%**	**85.48%**	88.56%	3.08
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.37%	**85.14%**	86.54%	88.83%	2.29
*Asthma Medication Ratio^*	—	**51.24%**	**54.41%**	57.73%	3.32
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	65.69%	**48.66%**	65.94%	64.72%	-1.22
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	81.51%	50.61%	57.91%	60.34%	2.43

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	54.50%	**36.98%**	55.96%	56.45%	0.49
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	37.71%	**54.50%**	35.77%	32.85%	-2.92
*Comprehensive Diabetes Care—HbA1c Testing^*	88.56%	86.86%	88.08%	89.29%	1.21
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	91.24%	89.05%	**88.08%**	89.78%	1.70
Controlling High Blood Pressure	—	—	—	63.26%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Gold Coast—Ventura County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	3	3	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	6	0.00%

Assessment of Improvement Plans—Care for Chronic Conditions

Based on reporting year 2018 performance measure results, DHCS required Gold Coast to conduct PDSA cycles for the following measures:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Asthma Medication Ratio*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs

To improve the MCP's performance on the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure, Gold Coast conducted monthly manual medical record reviews on 10 percent of the non-compliant beneficiaries. From the first PDSA cycle, the MCP learned that the lab report of non-compliant beneficiaries was inaccurate. The MCP discovered that the lab data reported some beneficiaries who completed the lab services as being non-compliant because the lab vendor used a data-centric approach suitable for fee-for-service providers to capture lab services completed for the MCP's beneficiaries. For the second PDSA cycle, Gold Coast attempted to work with the lab vendor to implement a member-centric data reporting process; however, due to the anticipated high implementation and monthly fee costs, the MCP decided not to pursue testing the use of member-centric data intervention.

The rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure improved significantly from reporting year 2018 to reporting year 2019, resulting in the rate moving from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019.

Note that outside of the IP process, Gold Coast implemented strategies to improve the MCP's performance on the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure. See Table 8.1 for the actions Gold Coast reported during the review period to improve the MCP's performance on this measure.

Asthma Medication Ratio

To improve the MCP's performance on the *Asthma Medication Ratio* measure, Gold Coast conducted two PDSA cycles. The cycles included the MCP's pharmacy benefit manager (PBM) faxing letters to providers at three clinics with beneficiaries who had a ratio for controller medications to total asthma medications of less than 0.50. The second PDSA cycle included a beneficiary outreach component; however, communication challenges between the MCP and the clinic partner resulted in a discontinuance of beneficiary outreach during the third PDSA cycle.

The rate for the *Asthma Medication Ratio* measure moved from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019.

Note that outside of the IP process, Gold Coast implemented strategies to improve the MCP's performance on the *Asthma Medication Ratio* measure. See Table 8.1 for the actions Gold Coast reported during the review period to improve the MCP's performance on this measure.

Comprehensive Diabetes Care—Medical Attention for Nephropathy

To improve the MCP's performance on the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure, Gold Coast conducted two PDSA cycles. The first PDSA cycle tested whether conducting an academic detailing intervention at a targeted clinic would

increase utilization of the microalbumin urine test for diabetic nephropathy screening. The intervention was abandoned due to challenges coordinating with the clinic partner to conduct the presentations. For the second PDSA cycle, Gold Coast's clinic partner incorporated dot phrases into the clinics' electronic medical records that prompted the providers to order a microalbumin urine test if beneficiaries had not completed a diabetic nephropathy screening test within the prior 12 months.

The rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure moved from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019.

Note that outside of the IP process, Gold Coast implemented strategies to improve the MCP's performance on the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure. See Table 8.1 for the actions Gold Coast reported during the review period to improve the MCP's performance on this measure.

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.

- Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.

- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results Gold Coast—Ventura County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG

suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	41.05	40.20	41.21	41.79	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	246.05	263.85	271.06	275.07	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	25.58%	29.27%	32.75%	35.21%	2.46
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Plan All-Cause Readmissions***	—	—	—	14.31%	Not Comparable
Use of Imaging Studies for Low Back Pain	73.51%	73.89%	69.01%	69.90%	0.89

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Gold Coast—Ventura County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of Gold Coast's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high

performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:

- *Asthma Medication Ratio*
- *Breast Cancer Screening*
- *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains Gold Coast—Ventura County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	19	5.26%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	4	19	21.05%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	3	3	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	16	0.00%

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table
Gold Coast—Ventura County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.12.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	71.34	71.60	72.55	69.12	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	440.50	470.59	490.65	497.82	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.21%	89.12%	89.73%	91.61%	1.88
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.47%	90.36%	91.41%	93.30%	1.89
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	88.64%	85.00%	91.18%	93.55%	2.37
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.59%	88.14%	87.69%	87.73%	0.04
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.55%	90.21%	91.07%	91.29%	0.22

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	86.58%	86.54%	86.57%	88.21%	1.64
*Plan All-Cause Readmissions***	—	—	—	17.14%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
Gold Coast—Ventura County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	39.38	38.63	39.66	40.42	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	235.33	253.54	260.25	263.90	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.29%	84.07%	84.50%	87.84%	3.34
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.40%	83.75%	85.44%	87.75%	2.31
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.72%	93.96%	95.09%	94.44%	-0.65
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	84.81%	85.46%	84.64%	86.80%	2.16
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	85.49%	84.37%	85.99%	87.64%	1.65

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.04%	82.18%	83.60%	85.08%	1.48
*Plan All-Cause Readmissions***	—	—	—	13.56%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Gold Coast—Ventura County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	69.12	40.42	Not Tested	41.79

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	497.82	263.90	Not Tested	275.07
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.61%	87.84%	3.77	88.56%
Annual Monitoring for Patients on Persistent Medications—Diuretics	93.30%	87.75%	5.55	88.83%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	93.55%	94.44%	-0.89	94.43%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.73%	86.80%	0.93	86.82%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.29%	87.64%	3.65	87.74%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.21%	85.08%	3.13	85.17%
*Plan All-Cause Readmissions***	17.14%	13.56%	3.58	14.31%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that Gold Coast stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, Gold Coast had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the following measures:
  - Both *Annual Monitoring for Patients on Persistent Medications* measures
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*

- The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
  - Both *Annual Monitoring for Patients on Persistent Medications* measures
  - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*
- The reporting year 2019 SPD rate was significantly worse than the reporting year 2019 non-SPD rate for the *Plan All-Cause Readmissions* measure. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that Gold Coast followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for Gold Coast:

- The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure was above the high performance level, and all other rates were above the minimum performance levels.
- Across all domains, the rates for the following four of 19 measures (21 percent) improved significantly from reporting year 2018 to reporting year 2019:
  - Both *Annual Monitoring for Patients on Persistent Medications* measures, resulting in the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure moving from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019.
  - *Breast Cancer Screening*
  - *Prenatal and Postpartum Care—Postpartum Care*
- The rates for the following two measures improved from reporting year 2018 to reporting year 2019. While the improvement was not statistically significant, the changes resulted in the rates moving from below the minimum performance levels in reporting year 2018 to above the minimum performance levels in reporting year 2019:
  - *Asthma Medication Ratio*
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Opportunities for Improvement—Performance Measures

Based on Gold Coast's reporting year 2019 performance measure results, HSAG has no recommendations for the MCP in the area of performance measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, Gold Coast conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's module submissions for both these PIPs as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required Gold Coast to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, Gold Coast identified diabetes poor HbA1c control among non-English-speaking Hispanic/Latino beneficiaries as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—Gold Coast *Diabetes Poor HbA1c Control* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of poor blood glucose levels (HbA1c >9.0 percent) among beneficiaries 18 to 75 years of age, non-English-speaking Hispanic/Latinos, living with diabetes, who are enrolled at Provider Group A.[6]	70.39%	59.20%

Intervention Testing

Prior to the intervention testing phase of the MCP's *Diabetes Poor HbA1c Control* Disparity PIP, HSAG reviewed and provided feedback to Gold Coast on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Gold Coast that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the intervention that Gold Coast tested for its *Diabetes Poor HbA1c Control* Disparity PIP. The table also indicates the key drivers that the intervention addressed.

[6] Provider group name removed for confidentiality.

Table 4.2—Gold Coast *Diabetes Poor HbA1c Control* Disparity PIP Intervention Testing

Intervention	Key Drivers Addressed
Provide Provider Group A with a monthly report of beneficiaries who have had no HbA1c test completed so the clinic can provide point-of-care HbA1c tests and diabetes education. The report will be sent to appropriate outreach staff at the clinic and will include the most recent contact information Gold Coast has on record.	♦ Clinic unable to reach beneficiaries. ♦ Language barriers. ♦ Cultural barriers. ♦ Data management and reporting. ♦ Lack of beneficiary knowledge on how to manage diabetes. ♦ Beneficiaries are non-compliant with treatment plans and doctor's orders.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Gold Coast and conducted technical assistance calls with the MCP staff members to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although Gold Coast completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Gold Coast's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required Gold Coast to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, Gold Coast selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—Gold Coast *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of *Childhood Immunization Status—Combination 3* measure for Provider Group B[7]	73.64%	83.64%

[7] Provider group name removed for confidentiality.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 3* PIP, HSAG reviewed and provided feedback to Gold Coast on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Gold Coast that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the interventions that Gold Coast tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

Table 4.4—Gold Coast *Childhood Immunization Status—Combination 3* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Implement a coordinated MCP/clinic telephonic outreach program to schedule child immunization appointments.	♦ No clinic staff are assigned to conduct outreach. ♦ Educate parents/guardians on the importance of child immunizations. ♦ Inform parents/guardians which child immunizations are incomplete. ♦ Schedule immunization appointments.
Implement a process for the clinic to assess the immunization status of all beneficiaries less than 2 years of age who have a clinic visit with Provider Group B.	♦ MCP does not always have the most up-to-date claims/encounter and supplemental data to produce the most up-to-date gap reports for outreach.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Gold Coast and conducted technical assistance calls with MCP staff members to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although Gold Coast completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Gold Coast's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, Gold Coast submitted to HSAG all required documentation about planned interventions during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on Gold Coast's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[8] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with Gold Coast, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from Gold Coast's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of Gold Coast's self-reported actions.

Table 8.1—Gold Coast's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. For HEDIS performance measure reporting: a. Ensure inclusion of appropriate eligibility spans for newborns. b. Implement a formal process to track and document quality HEDIS audit results.	Ensure inclusion of appropriate eligibility spans for newborns: ♦ The full-scope Medi-Cal Aid codes and count of active member months continue to be the primary indicators to ensure inclusion of appropriate eligibility spans for all members, including newborns. At birth, Medi-Cal temporarily assigns newborns the same member identifier as their mother; however, newborns who become Medi-Cal eligible are assigned a unique member identifier which is retroactively assigned to their first date of enrollment. This process ensures incorporating the newborn's entire eligibility span when assessing eligibility for inclusion in HEDIS and other performance measures. ♦ In the 2017–18 ROADMAP, Section 2: Enrollment, Gold Coast reported that the MCP's membership software, Visiant Inc., assigns a "B1" code to newborn claims up to the first two months of life or until the baby is assigned a unique member identifier, to differentiate between the mother's and baby's claims. However, the "B1" code is not used as an indicator for eligibility.

<table>
<tr><th>2017–18 External Quality Review Recommendations Directed to Gold Coast</th><th>Self-Reported Actions Taken by Gold Coast during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations</th></tr>
<tr><td></td><td>Implement a formal process to track and document HEDIS quality audit results:
The Quality Improvement Department maintains and tracks all processes and outcomes of each annual HEDIS Compliance Audit. All audit-related documents are stored in folders, designated by year and audit category (e.g., ROADMAP) within a secure network drive that is maintained by staff in the Quality Improvement Department. Designated folders include:
Annual ROADMAPs.
Annual HSAG_NCQA HEDIS Audits and Outcomes.
Annual Healthcare Organization Questionnaire.
Annual HEDIS Timelines and Due Dates.
Annual EQRO Performance Evaluation.</td></tr>
<tr><td>2. Assess the causes for the rates for the following measures being below the minimum performance levels in reporting year 2018, and identify strategies for improving the MCP's performance:
a. Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs
b. Asthma Medication Ratio
c. Comprehensive Diabetes Care—Medical Attention for Nephropathy</td><td>Reporting Year 2018 and Reporting Year 2019 Rate Comparison Table
<table>
<tr><th>Measure</th><th>Reporting Year 2018 Rate</th><th>Reporting Year 2019 Rate</th><th>Rate Change</th><th>Reporting Year 2019 Percentile Rank</th></tr>
<tr><td>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</td><td>85.48</td><td>88.56</td><td>+3.08</td><td>50th</td></tr>
<tr><td>Asthma Medication Ratio</td><td>54.41</td><td>57.73</td><td>+3.32</td><td>25th</td></tr>
<tr><td>Comprehensive Diabetes Care—Medical Attention for Nephropathy</td><td>88.08</td><td>89.78</td><td>+1.70</td><td>25th</td></tr>
</table></td></tr>
</table>

2017–18 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs Causes for declining performance and performance below the minimum performance level in reporting year 2018: ♦ The results of the 2017–18 PDSA cycle (for reporting year 2017) revealed that the monthly lab files produced by Quest Diagnostics did not contain a complete summary of labs completed on Gold Coast members who had labs ordered at one of the clinic partners. Therefore, the reporting year 2018 *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* rate continued to be underreported due to missing lab data not received from Quest Diagnostics. Actions taken by the MCP to improve the measure: ♦ The Quality Improvement and Information Technology departments collaborated with Quest Diagnostics to identify the root cause of the data deficiencies in Quest Diagnostic's monthly lab files and to find a solution to improve the monthly reporting process. ♦ The Quality Improvement Department created a nonstandard supplemental database to collect the lab data missing in Quest Diagnostics' 2018 monthly lab files by collecting the lab data through medical record reviews. ♦ The Quality Improvement Department worked with an external vendor to implement an end-of-year gaps in care outreach program to schedule lab appointments. ♦ The Quality Improvement Department increased provider awareness about the performance measure through the following activities: ■ Updates at Quality Improvement Committee meetings. ■ Distribution of the annual reporting year 2018/measurement year 2017 HEDIS report cards. ■ Provided each clinic system with comparative graphs of reporting year 2018/measurement year 2017 performance rates to compare the clinic system's performance with other clinic systems (whose clinic

2017–18 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	names were blinded) to enable peer-to-peer performance evaluation and institute improvement. ■ Distribution of three measurement year 2018 HEDIS progress reports and member-level gap reports. ■ Provider Tip Sheets. ■ Provider communications (e.g., provider memos and articles in the quarterly Provider Operations Bulletin). ■ MCP, clinic system, and community collaboratives (e.g., joint operation meetings, Child Health and Disability Prevention Program). Outcome: ♦ The *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure rate increased 3.08 percentage points, from 85.48 to 88.56, which improved Gold Coast's performance from the national Medicaid 10th percentile to the national Medicaid 50th percentile. ***Asthma Medication Ratio*** Causes for declining performance and performance below the minimum performance level in reporting year 2018: ♦ A barrier analysis completed in August 2018 revealed that the provider-level rates for five of the seven contracted provider groups were in the 10th percentile ranking, indicating that the decreased *Asthma Medication Ratio* rate was attributed to lack of provider-level asthma medication management. ♦ Ongoing evaluations and provider feedback during the two PDSA cycles revealed that emergency department and urgent care providers often prescribed short-acting reliever medications to help alleviate or prevent any respiratory complications. However, these patients did not always follow up with their primary care provider (PCP) to establish an asthma medication management care plan either because they did not know their assigned PCP or did not seek clinical care until their condition worsened.

2017–18 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	Actions taken by the MCP to improve the measure: ♦ The Quality Improvement Department collaborated with Gold Coast's PBM, Optum Rx, to monitor the PBM's provider outreach campaign focused on improving provider awareness and clinical care by informing providers which patients had suboptimal controller to total asthma medications and needed asthma medication management. ♦ The Quality Improvement Department also attempted collaboration with one contracted provider group to test the effectiveness of a clinic-driven member outreach program to supplement the Optum Rx provider outreach campaign. ♦ The Quality Improvement Department worked with an external vendor to implement an end-of-year gaps in care outreach program to schedule primary care appointments. ♦ The Quality Improvement Department increased provider awareness on the performance measure through the following activities: ■ Updates at Quality Improvement Committee meetings. ■ Distribution of the annual reporting year 2018/measurement year 2017 HEDIS report cards. ■ Provided each clinic system with comparative graphs of reporting year 2018/measurement year 2017 performance rates to compare the clinic system's performance with other clinic systems (whose clinic names were blinded) to enable peer-to-peer performance evaluation and institute improvement. ■ Distribution of three measurement year 2018 HEDIS progress reports and member-level gap reports. ■ Provider Tip Sheets. ■ Provider communications (e.g., provider memos and articles in the quarterly Provider Operations Bulletin). ■ MCP, clinic system, and community collaboratives (e.g., joint operation meetings, Child Health and Disability Prevention Program). Outcome: ♦ The *Asthma Medication Ratio* rate increased 3.32 percentage points, from 54.41 to 57.73, which improved

2017–18 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	Gold Coast's performance from the national Medicaid 10th percentile to the national Medicaid 25th percentile. ***Comprehensive Diabetes Care—Medical Attention for Nephropathy*** Causes for declining performance and performance below the minimum performance level in reporting year 2018: ♦ A barrier analysis completed in July 2018 revealed that a large clinic system used both the microalbumin urine test and complete metabolic panel (CMP) test to monitor kidney function in diabetic patients. However, there was a greater tendency for this large clinic system's providers to order the CMP test, which is not aligned with the HEDIS measure specifications for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure. ♦ Ongoing evaluations and provider feedback during the first PDSA cycle revealed that the CMP test was a standard test providers ordered to monitor kidney function and that the microalbumin urine test was ordered more on a case-by-case basis, depending on the results of the CMP test, and as needed by the provider. Actions taken by the MCP to improve the measure: ♦ Under the leadership of Gold Coast's chief medical officer, the Quality Improvement Department created a Clinical Leadership Team to test the effectiveness of an academic detailing intervention for clinic staff. The intervention was focused on increasing the utilization of the microalbumin urine test for diabetic nephropathy screening by using evidence-based clinical practice guidelines and HEDIS measure specifications to educate providers at a high-volume/low-performing clinic. ♦ In response to Gold Coast's feedback, the clinic updated an existing diabetes "dot phrase," a documentation tool within the clinic's electronic health record that auto-populates text in clinic notes, to include a message that informs clinicians to order a microalbumin urine test if no diabetic nephropathy screening was completed within the last 12 months. The Quality Improvement Department evaluated the

2017–18 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	effectiveness of the diabetes dot phrase and found that more than 80 percent of the clinic's clinicians who used the diabetes dot phrase ordered a microalbumin urine test to monitor nephropathy, which indicates that the dot phrase enhancement was effective with increasing provider awareness and improving the quality of patient care. ♦ The Quality Improvement Department worked with an external vendor to implement an end-of-year gaps in care outreach program to schedule lab appointments. ♦ The Quality Improvement Department increased provider awareness on the performance measure through the following activities: ■ Updates at Quality Improvement Committee meetings. ■ Distribution of the annual reporting year 2018/measurement year 2017 HEDIS report cards. ■ Provided each clinic system with comparative graphs of reporting year 2018/measurement year 2017 performance rates to compare the clinic system's performance with other clinic systems (whose clinic names were blinded) to enable peer-to-peer performance evaluation and institute improvement. ■ Distribution of three measurement year 2018 HEDIS progress reports and member-level gap reports. ■ Provider Tip Sheets. ■ Provider communications (e.g., provider memos and articles in the quarterly Provider Operations Bulletin). ■ MCP, clinic system, and community collaboratives (e.g., joint operation meetings, Child Health and Disability Prevention Program). Outcome: ♦ The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* rate increased 1.70 percentage points, from 88.08 to 89.78, which improved Gold Coast's performance from the national Medicaid 10th percentile to the national Medicaid 25th percentile.

<table>
<tr><th>2017–18 External Quality Review Recommendations Directed to Gold Coast</th><th>Self-Reported Actions Taken by Gold Coast during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations</th></tr>
<tr><td>3. Identify the causes for the rate declining significantly from RY 2017 to RY 2018 for the Use of Imaging Studies for Low Back Pain measure to ensure that only beneficiaries ages 18 to 50 with lower back pain and who show clinical necessity receive an imaging study.</td><td>
Reporting Year 2018 and Reporting Year 2019 Rate Comparison Table
<table>
<tr><th>Measure</th><th>Reporting Year 2018 Rate</th><th>Reporting Year 2019 Rate</th><th>Rate Change</th><th>Reporting Year 2019 Percentile Rank</th></tr>
<tr><td>Use of Imaging Studies for Low Back Pain</td><td>69.01</td><td>69.90</td><td>+0.89</td><td>25th</td></tr>
</table>
Causes for the rate declining from reporting year 2017 to reporting year 2018:
♦ A preliminary analysis of members who had imaging studies within 28 days of their diagnoses of low back pain revealed that greater than 50 percent (217 of 391) of the imaging studies were completed at one specific clinic. A focused review of a sample of members assigned to this clinic showed that the imaging studies were completed on the same day as the diagnosis of low back pain. However, additional research to confirm if the imaging studies were attributed to specific providers within the clinic system was not completed.
Actions taken by the MCP to improve the measure:
♦ The Quality Improvement Department increased provider awareness on the performance measure through the following activities:
■ Updates at Quality Improvement Committee meetings.
■ Distribution of the annual reporting year 2018 HEDIS report cards.
■ Provided each clinic system with comparative graphs of reporting year 2018/measurement year 2017 performance rates to compare their performance with other clinic systems (whose clinic names were blinded) to enable peer-to-peer performance evaluation and institute improvement.
</td></tr>
</table>

<table>
<tr><th>2017–18 External Quality Review Recommendations Directed to Gold Coast</th><th>Self-Reported Actions Taken by Gold Coast during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations</th></tr>
<tr><td></td><td>

Distribution of three reporting year 2019 HEDIS progress reports.
Provider Tip Sheets.
Provider communications (e.g., provider memos and articles in the quarterly Provider Operations Bulletin).

Outcome:

The Use of Imaging Studies for Low Back Pain rate did not improve significantly, with only a 0.89 percentage point rate increase.

</td></tr>
<tr><td>4. Continue monitoring interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2015–17 Immunizations of Two-Year-Olds and Developmental Screening for Children PIPs.</td><td>
Reporting Year 2018 and Reporting Year 2019 Rate Comparison Table
<table>
<tr><th>Measure</th><th>Reporting Year 2018 Rate</th><th>Reporting Year 2019 Rate</th><th>Rate Change</th><th>Reporting Year 2019 Percentile Rank</th></tr>
<tr><td>Childhood Immunization Status—Combination 3</td><td>70.53</td><td>75.67</td><td>+5.14</td><td>75th</td></tr>
<tr><td>Developmental Screening for Children</td><td>NR</td><td>NR</td><td>NA</td><td>NA</td></tr>
</table>
NR = Not Reported in the DHCS External Accountability Set
NA = Not applicable

Childhood Immunization Status

The Quality Improvement Department continued collaborations with a new clinic partner to test interventions for improving childhood immunizations in children under 2 years of age.
Gold Coast sponsored a student nurse leadership research project focused on improving childhood immunizations.
The Quality Improvement Department increased provider awareness on the performance measure through the following activities:

Updates at Quality Improvement Committee meetings.
Distribution of the annual reporting year 2018/ measurement year 2017 HEDIS report cards.

</td></tr>
</table>

2017–18 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	■ Provided each clinic system with comparative graphs of reporting year 2018 /measurement year 2017 performance rates to compare the clinic system's performance with other clinic systems (whose clinic names were blinded) to enable peer-to-peer performance evaluation and institute improvement. ■ Distribution of three measurement year 2018 HEDIS progress reports and member-level gap reports. ■ Provider Tip Sheets. ■ Provider communications (e.g., provider memos and articles in the quarterly Provider Operations Bulletin). ■ MCP, clinic system, and community collaboratives (e.g., joint operation meetings, Child Health and Disability Prevention Program). ***Developmental Screening for Children*** ♦ Gold Coast's Health Services Department continued to monitor provider utilization of developmental screenings in children and adolescents through monthly reports generated by Gold Coast's Decision Support Services Department that included the following parameters: ■ Annual rate by year ■ Annual rate by type of visit (wellness vs. non-wellness) ■ Clinic system ♦ Gold Coast's Health Services Department also reviewed developmental screening utilization outcomes with the Children Health and Disability Prevention Programs and Help Me Grow Ventura County. ♦ With the transition of the DHCS performance measure set from the External Accountability Set to the Managed Care Accountability Set (MCAS), Gold Coast will begin reporting the *Developmental Screening for the First Three Years of Life* measure. The Quality Improvement Department is implementing initiatives to monitor and improve performance of this measure and increase provider awareness through the following activities: ■ Updates at Quality Improvement Committee meetings.

2017–18 External Quality Review Recommendations Directed to Gold Coast	Self-Reported Actions Taken by Gold Coast during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	■ Include the *Developmental Screening for the First Three Years of Life* measure in the annual progress reports and member-level gap reports. ■ Develop Provider Tip Sheets for the *Developmental Screening for the First Three Years of Life* measure. ■ Provider communications (e.g., provider memos and articles in the quarterly Provider Operations Bulletin). ■ MCP, clinic system, and community collaboratives (e.g., joint operation meetings, Child Health and Disability Prevention Program).

Assessment of MCP's Self-Reported Actions

HSAG reviewed Gold Coast's self-reported actions in Table 8.1 and determined that Gold Coast adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. Gold Coast described in extensive detail actions taken during the review period, lessons learned, and steps the MCP plans to take moving forward. Gold Coast described specific interventions the MCP implemented to improve performance to above the minimum performance levels or prevent further decline in performance. Some of the MCP's described actions may have contributed to the improvement HSAG noted in Section 3 of this report ("Managed Care Health Plan Performance Measures") under the Strengths—Performance Measures heading.

2018–19 Recommendations

Based on the overall assessment of Gold Coast's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the MCP.

In the next annual review, HSAG will evaluate continued successes of Gold Coast.

Appendix P:
Performance Evaluation Report
Health Net Community Solutions, Inc.
July 1, 2018–June 30, 2019

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Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Health Net Community Solutions, Inc. ("Health Net" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in Health Net's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Health Net is a full-scope MCP delivering services to beneficiaries as a commercial MCP under the Two-Plan Model (TPM) and also under a Geographic Managed Care (GMC) model.

Table 1.1 shows the counties in which Health Net provided services to beneficiaries under the TPM and denotes which MCP is the "Local Initiative." Beneficiaries may enroll in Health Net, the commercial MCP; or in the alternative Local Initiative.

Table 1.1—Local Initiative Plans under the Two-Plan Model in Counties in which Health Net Serves as the Commercial Managed Care Health Plan

County	Local Initiative Plan
Kern	Kern Family Health Care
Los Angeles	L.A. Care Health Plan
San Joaquin	Health Plan of San Joaquin
Stanislaus	Health Plan of San Joaquin
Tulare	Anthem Blue Cross Partnership Plan

Health Net operates under a GMC model in the counties of Sacramento and San Diego. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

In addition to Health Net, Sacramento County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Anthem Blue Cross Partnership Plan
- Kaiser NorCal
- Molina Healthcare of California Partner Plan, Inc.

In addition to Health Net, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Shield of California Promise Health Plan (known as Care1st Partner Plan prior to January 1, 2019)
- Community Health Group Partnership Plan
- Kaiser SoCal
- Molina Healthcare of California Partner Plan, Inc.
- UnitedHealthcare Community Plan

Health Net became operational in Sacramento County to provide MCMC services in 1994 and then expanded to additional contracted counties, the most recent being San Joaquin County, effective January 2013. Table 1.2 shows the number of beneficiaries enrolled in Health Net for each county, Health Net's percentage of beneficiaries enrolled in each county, and the MCP's total number of beneficiaries as of June 2019.[1]

Table 1.2—Health Net Enrollment as of June 2019

County	Enrollment as of June 2019	Health Net's Percentage of Beneficiaries Enrolled in the County
Kern	66,732	21%
Los Angeles	951,707	32%
Sacramento	106,078	25%
San Diego	67,334	10%
San Joaquin	20,166	9%
Stanislaus	62,978	33%
Tulare	110,649	55%
Total	1,385,644	

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Health Net. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Health Net. A&I conducted the audits from May 21, 2018, through June 1, 2018.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Health Net
Audit Review Period: May 1, 2017, through April 30, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	No	No findings.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in the Utilization Management, Access and Availability of Care, Administrative and Organizational Capacity, and State Supported Services categories during the 2018 Medical and State Supported Services Audits of Health Net.

Opportunities for Improvement—Compliance Reviews

Health Net has the opportunity to work with DHCS to ensure that the MCP fully resolves all findings from the 2018 Medical and State Supported Services Audits.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for Health Net Community Solutions, Inc.* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that Health Net followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.63 for Health Net's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.63:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.56 present the performance measure results and findings by domain, and Table 3.57 through Table 3.63 present the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.
- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 through Table 3.7 present the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1 through Table 3.7:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Health Net—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**61.48%**	**58.93%**	**54.61%**	**59.90%**	5.29
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**87.95%**	**89.96%**	**89.16%**	**90.35%**	1.19

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**78.86%**	**78.46%**	**78.86%**	**79.37%**	0.51
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**75.28%**	**75.39%**	**77.10%**	**77.80%**	0.70
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**75.39%**	**75.71%**	**77.06%**	**77.93%**	0.87
Immunizations for Adolescents—Combination 2	—	20.44%	32.60%	31.39%	-1.21
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	76.15%	82.53%	77.05%	72.13%	-4.92

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	68.68%	75.95%	72.13%	67.49%	-4.64
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.22%	70.77%	67.24%	67.21%	-0.03

Table 3.2—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Health Net—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	80.51%	75.93%	66.13%	67.12%	0.99
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**88.04%**	**89.65%**	**89.91%**	**90.08%**	0.17
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**78.36%**	**79.66%**	**80.77%**	**81.91%**	1.14
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**84.13%**	**84.53%**	**85.33%**	**85.29%**	-0.04
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**79.55%**	**80.22%**	**81.61%**	**82.27%**	0.66
Immunizations for Adolescents—Combination 2	—	24.82%	35.77%	39.66%	3.89
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	77.49%	82.50%	79.66%	79.38%	-0.28

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	70.18%	75.00%	72.88%	76.55%	3.67
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.13%	71.34%	76.32%	74.43%	-1.89

Table 3.3—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Health Net—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**60.82%**	**62.28%**	**56.96%**	**53.09%**	-3.87
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**88.46%**	**88.76%**	**91.02%**	**92.55%**	1.53
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**76.60%**	**76.68%**	**79.06%**	**80.99%**	1.93
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**80.90%**	**79.85%**	**80.91%**	**81.24%**	0.33
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**77.23%**	**77.18%**	**77.81%**	**79.12%**	1.31
Immunizations for Adolescents—Combination 2	—	27.49%	33.58%	37.23%	3.65
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	69.27%	73.66%	76.50%	78.74%	2.24

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	56.25%	67.80%	71.86%	76.44%	4.58
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**61.67%**	64.80%	71.05%	70.18%	-0.87

Table 3.4—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Health Net—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	72.27%	75.52%	68.37%	**63.89%**	-4.48
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**92.41%**	**90.95%**	**88.07%**	**88.60%**	0.53
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**81.86%**	**83.01%**	**80.76%**	**80.41%**	-0.35
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**86.81%**	**86.87%**	**86.33%**	**85.69%**	-0.64
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**83.38%**	**82.75%**	**82.25%**	**83.05%**	0.80
Immunizations for Adolescents—Combination 2	—	16.79%	30.90%	31.14%	0.24
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	69.85%	67.01%	74.62%	73.16%	-1.46

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	65.67%	62.11%	70.85%	70.62%	-0.23
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.75%	73.10%	73.17%	72.56%	-0.61

Table 3.5—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Health Net—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**54.89%**	**55.26%**	**58.72%**	**60.80%**	2.08
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**83.15%**	**85.17%**	**87.84%**	**85.49%**	-2.35
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**66.95%**	**72.98%**	**75.42%**	**76.58%**	1.16
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**74.38%**	**71.12%**	**71.36%**	**72.68%**	1.32
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**72.92%**	**71.70%**	**72.28%**	**74.99%**	2.71
Immunizations for Adolescents—Combination 2	—	11.75%	25.39%	29.04%	3.65
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	64.09%	59.37%	62.44%	67.64%	5.20

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	51.37%	54.26%	55.85%	63.02%	7.17
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**56.87%**	**59.75%**	**60.05%**	**60.76%**	0.71

Table 3.6—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Health Net—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**61.44%**	**58.42%**	**59.10%**	**60.55%**	1.45
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**90.02%**	**89.98%**	**89.16%**	**89.58%**	0.42
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**81.60%**	**79.67%**	**78.59%**	**80.16%**	1.57
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**84.68%**	**81.68%**	**81.05%**	**82.10%**	1.05
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**80.73%**	**78.19%**	**77.42%**	**79.32%**	1.90
Immunizations for Adolescents—Combination 2	—	16.79%	26.28%	27.74%	1.46
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	67.35%	68.11%	69.21%	71.28%	2.07

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	66.84%	68.62%	67.11%	68.35%	1.24
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**63.74%**	69.01%	**62.15%**	69.07%	6.92

Table 3.7—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Health Net—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	73.21%	74.39%	72.90%	77.91%	5.01
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.80%	94.67%	96.27%	96.95%	0.68
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.27%	88.40%	89.84%	90.10%	0.26
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.82%	89.76%	90.03%	91.01%	0.98
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.55%	87.52%	87.96%	89.32%	1.36
Immunizations for Adolescents—Combination 2	—	31.39%	43.31%	40.88%	-2.43
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	81.11%	80.83%	82.79%	87.54%	4.75

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	76.94%	75.40%	78.14%	81.47%	3.33
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.96%	75.61%	78.91%	68.40%	-10.51

Table 3.8 through Table 3.14 present findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.8 through Table 3.14:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.8—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—Kern County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	5	20.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	4	25.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	4	0.00%

Table 3.9—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—Los Angeles County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.10—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	5	20.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	4	25.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	4	0.00%

Table 3.11—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—San Diego County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	5	20.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	5	20.00%

Table 3.12—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—San Joaquin County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	2	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	5	40.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	2	4	50.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.13—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—Stanislaus County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	2	50.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	5	20.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	4	25.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.14—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—Tulare County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	5	40.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	4	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Assessment of Corrective Action Plan—Preventive Screening and Children's Health

Based on reporting year 2018 performance measure results, DHCS required Health Net to conduct improvement activities for the following measures within the Preventive Screening and Children's Health domain as part of the MCP's CAP:

- *Childhood Immunization Status—Combination 3* in Kern, Sacramento, San Joaquin, and Stanislaus counties
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in San Joaquin and Stanislaus counties

Childhood Immunizations

DHCS previously approved Health Net to conduct a PIP to address the MCP's performance below the minimum performance level for multiple years for the *Childhood Immunization Status—Combination 3* measure in Kern, Sacramento, San Joaquin, and Stanislaus counties. The MCP's 2017–19 *Childhood Immunization Status—Combination 3* PIP has a narrowed focus on a provider group in Kern County. HSAG includes a summary of Health Net's progress on this PIP in Section 5 of this report ("Performance Improvement Projects").

The *Childhood Immunization Status—Combination 3* measure rates remained below the minimum performance level in Kern, Sacramento, San Joaquin, and Stanislaus counties in reporting year 2019.

Well-Child Visits

Health Net conducted two PDSA cycles to address the MCP's performance below the minimum performance level in reporting year 2018 for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure.

For the first PDSA cycle, Health Net tested whether partnering with a clinic to offer in-home well-child visits for Health Net pediatric beneficiaries ages 3 to 6 years in San Joaquin County who had not been seen for a well-child visit in 2018 would improve the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate in San Joaquin County. The MCP reported that the clinic had difficulty implementing the home visits intervention, leading to delayed outreach to beneficiaries. Additionally, compared to the number of completed appointments, a high number of beneficiaries refused the home visit option, resulting in the MCP abandoning the intervention.

For the second PDSA cycle, Health Net tested whether offering a weekend well-child clinic to beneficiaries who live within five miles from Health Net's Community Resource Center in San Joaquin County, combined with a beneficiary incentive, would improve the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate in San Joaquin County. In addition to calling beneficiaries, the MCP also dispatched the Health Net Member Connection team to visit beneficiary households to schedule appointments. Although the MCP reported having difficulty scheduling beneficiaries for the clinic, the proximity of the clinic, face-to-face

outreach to schedule appointments, and beneficiary incentive for completing the well-child visit resulted in a high turnout. In addition, some parents reported that they were motivated to attend the clinic because they were able to schedule well-child visits for multiple children on the same day and receive multiple incentives. Health Net indicated that the success of the clinic identified the opportunity for the MCP to explore ways to address care gaps for other household members and design clinics that can address preventive health for the entire family.

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate improved significantly from reporting year 2018 to reporting year 2019 in Stanislaus County, resulting in the rate moving to above the minimum performance level in reporting year 2019. The rate for this measure in San Joaquin County remained below the minimum performance level in reporting year 2019. Note that Health Net conducted the PDSA cycles in San Joaquin County; therefore, the tested interventions did not contribute to the statistically significant improvement in the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate in Stanislaus County.

Preventive Screening and Women's Health

Table 3.15 through Table 3.21 present the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.15 through Table 3.21:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.15—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Health Net—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**48.30%**	**48.31%**	53.59%	5.28
Cervical Cancer Screening	**43.55%**	**43.31%**	**48.91%**	**51.58%**	2.67
Prenatal and Postpartum Care—Postpartum Care	58.99%	63.34%	65.10%	67.02%	1.92
Prenatal and Postpartum Care—Timeliness of Prenatal Care	77.97%	79.05%	**75.78%**	77.39%	1.61

Table 3.16—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Health Net—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	56.76%	56.99%	60.94%	3.95
Cervical Cancer Screening	**50.61%**	48.66%	59.12%	61.06%	1.94
Prenatal and Postpartum Care—Postpartum Care	55.72%	56.02%	**56.54%**	**56.05%**	-0.49
Prenatal and Postpartum Care—Timeliness of Prenatal Care	77.86%	78.62%	78.52%	78.02%	-0.50

Table 3.17—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Health Net—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**50.29%**	**50.06%**	53.81%	3.75
Cervical Cancer Screening	**40.63%**	**44.28%**	**49.39%**	**47.69%**	-1.70
Prenatal and Postpartum Care—Postpartum Care	57.11%	60.30%	**53.67%**	60.24%	6.57
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.29%	81.39%	81.01%	80.73%	-0.28

Table 3.18—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Health Net—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**42.44%**	**47.14%**	**51.33%**	4.19
Cervical Cancer Screening	**38.44%**	**42.58%**	**45.01%**	**47.20%**	2.19
Prenatal and Postpartum Care—Postpartum Care	56.30%	68.03%	60.00%	63.55%	3.55
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**75.63%**	76.23%	**74.15%**	78.04%	3.89

Table 3.19—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Health Net—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**46.97%**	**42.76%**	**43.89%**	1.13
Cervical Cancer Screening	**36.74%**	**37.71%**	**43.31%**	**45.99%**	2.68
Prenatal and Postpartum Care—Postpartum Care	57.97%	58.88%	**57.06%**	60.78%	3.72
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**72.95%**	77.66%	**75.71%**	78.43%	2.72

Table 3.20—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Health Net—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**47.46%**	**49.45%**	52.45%	3.00
Cervical Cancer Screening	**42.79%**	48.91%	**51.09%**	**47.20%**	-3.89
Prenatal and Postpartum Care—Postpartum Care	62.34%	63.92%	64.84%	62.37%	-2.47
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.29%	81.96%	81.51%	81.84%	0.33

Table 3.21—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Health Net—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	55.34%	57.44%	58.08%	0.64
Cervical Cancer Screening	56.51%	63.46%	62.76%	68.04%	5.28
Prenatal and Postpartum Care—Postpartum Care	62.50%	66.75%	64.69%	69.47%	4.78
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.02%	87.63%	87.33%	86.32%	-1.01

Table 3.22 through Table 3.28 present findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.22 through Table 3.28:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.22—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—Kern County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	2	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	1	0.00%

Table 3.23—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—Los Angeles County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.24—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	2	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	1	0.00%

Table 3.25—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	2	50.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	1	0.00%

Table 3.26—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—San Joaquin County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	3	66.67%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	0	N/A

Table 3.27—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—Stanislaus County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.28—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—Tulare County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Assessment of Corrective Action Plan—Preventive Screening and Women's Health

Based on reporting year 2018 performance measure results, DHCS required Health Net to conduct improvement activities for all four measures within the Preventive Screening and Women's Health domain as part of the MCP's CAP. For those counties listed, the following measures had rates below the minimum performance levels in reporting year 2018:

- *Breast Cancer Screening* in Kern, Sacramento, San Diego, San Joaquin, and Stanislaus counties
- *Cervical Cancer Screening* in Kern, Sacramento, San Diego, San Joaquin, and Stanislaus counties
- *Prenatal and Postpartum Care—Postpartum Care* in Los Angeles, Sacramento, and San Joaquin counties
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Kern, San Diego, and San Joaquin counties

Breast Cancer Screening

Health Net conducted two PDSA cycles to address the MCP's performance below the minimum performance level in reporting year 2018 for the *Breast Cancer Screening* measure.

For the first PDSA cycle, Health Net tested whether holding a mobile mammography event during regular clinic hours at a clinic in Kern County, along with conducting beneficiary outreach and offering a point-of-care incentive, would improve breast cancer screening compliance among noncompliant beneficiaries in the clinic. Health Net indicated that it may be helpful to survey beneficiaries to learn what motivated them most to attend the event. Additionally, Health Net reported that it may be helpful to have an MCP team member present at the event to help coordinate and handle unforeseen obstacles as well as to have the MCP represented at the event.

For the second PDSA cycle, Health Net tested whether holding a mobile mammography event during a Saturday clinic, along with conducting beneficiary outreach and offering a point-of-care incentive, would improve breast cancer screening compliance among noncompliant members within a specific ZIP code and within a two-mile radius of the clinic. The beneficiary

outreach consisted of phone calls to beneficiaries in the target group and home visits to beneficiaries the MCP was unable to reach via phone. Health Net reported learning that it was helpful for the MCP's Community Resource Center team to pre-fill the mobile mammography vendor pre-registration forms ahead of time rather than requiring the beneficiaries to complete the forms upon arrival. Additionally, the MCP reported an unanticipated barrier of 30 percent of the targeted beneficiaries declining an appointment for the following reasons:

- Prefer to go to their primary care provider (PCP) for care
- Do not want to have a mammogram due to cultural issues
- Work on Saturdays
- Too busy (already have plans for the day of the clinic)

The rates improved significantly from reporting year 2018 to reporting year 2019 for the *Breast Cancer Screening* measure in Kern, Sacramento, San Diego, and Stanislaus counties. The significant improvement resulted in the rates moving to above the minimum performance level in Kern, Sacramento, and Stanislaus counties; however, the rate remained below the minimum performance level in San Diego County. Additionally, the rate for this measure remained below the minimum performance level in San Joaquin County in reporting year 2019.

Cervical Cancer Screening

DHCS previously approved Health Net to conduct a PIP to address the MCP's continued performance below the minimum performance level for the *Cervical Cancer Screening* measure. The MCP's 2017–19 *Cervical Cancer Screening* Disparity PIP has a narrowed focus of cervical cancer screening among Mandarin-speaking Chinese beneficiaries. HSAG includes a summary of Health Net's progress on this PIP in Section 5 of this report ("Performance Improvement Projects").

In addition to the PIP, DHCS required Health Net to conduct PDSA cycles to address the MCP's performance below the minimum performance level for the *Cervical Cancer Screening* measure. Health Net conducted two PDSA cycles to help improve the MCP's performance.

For the first PDSA cycle, Health Net tested whether having community health workers conduct home visits to beneficiaries in Sacramento and San Joaquin counties who were noncompliant for their cervical cancer screenings would improve cervical cancer screening compliance. To allow the MCP to more easily monitor and evaluate the effort, and to allow for a more manageable number of beneficiaries with whom to conduct the home visits, the MCP targeted beneficiaries with at least one other care gap. Additionally, targeting another care gap provided the opportunity for the community health workers to provide guidance to the beneficiaries about managing their overall health care. During the home visits, the community health workers focused on the following:

- Scheduling appointments for the beneficiaries to complete their cervical cancer screenings
- Assisting with removing barriers to accessing health care (e.g., transportation, translator services)
- Promoting preventive health care practices

For the first PDSA cycle, Health Net reported learning the importance of having the community health workers promote the MCP's Cervical Cancer Screening Member Incentive Program when conducting the outreach as an additional means of motivation for the beneficiaries to complete their screening. Additionally, based on the number of beneficiaries who refused to schedule their screenings, the MCP determined that the community health workers should carry with them cervical cancer screening educational materials to leave with the beneficiaries in hopes that the beneficiaries would read the materials at a later date and recognize the importance of being compliant with their screenings.

For the second PDSA cycle, Health Net tested whether having the community health workers conduct home visits to beneficiaries in San Joaquin County who were noncompliant for their cervical cancer screenings would improve cervical cancer screening compliance. To allow the MCP to more easily monitor and evaluate the effort, and to allow for a more manageable number of beneficiaries with whom to conduct the home visits, the MCP targeted beneficiaries with a care gap in at least one of the following areas:

- Breast cancer screening
- Controlled high blood pressure
- HbA1c testing

After the second PDSA cycle, the MCP determined that the home visit intervention, which provided an opportunity for in-person beneficiary engagement, was successful. The MCP also noted that the intervention allowed for the community health workers to help beneficiaries with other aspects of their health care and overall daily life, allowing for a beneficiary-centered approach.

The rates for the *Cervical Cancer Screening* measure remained below the minimum performance level in reporting year 2019 in Kern, Sacramento, San Diego, San Joaquin, and Stanislaus counties.

Postpartum Care

DHCS required Health Net to submit a Pilot Quality Improvement Strategy Summary/Progress Report that described the quality improvement strategies the MCP implemented to address its performance below the minimum performance level for the *Prenatal and Postpartum Care—Postpartum Care* measure.

Health Net reported that in October 2018 the MCP implemented an intervention in Sacramento and Los Angeles counties to increase the number of beneficiaries who schedule a timely postpartum visit. The MCP conducted outreach via phone or home visits to beneficiaries who recently delivered a baby. When unable to reach beneficiaries after three attempts, the MCP's Member Retention Team informed the Member Connections Team, which then made unannounced home visits to these beneficiaries. During the home visits, the Member Connections Team conducted a postpartum mood and anxiety disorder assessment, referred the beneficiary to resources as needed, and ensured the beneficiary had a timely postpartum

appointment scheduled. The MCP reported that it will continue this intervention through December 31, 2019.

The rates for the *Prenatal and Postpartum Care—Postpartum Care* measure improved to above the minimum performance level in Sacramento and San Joaquin counties in reporting year 2019. The rate for this measure remained below the minimum performance level in Los Angeles County.

Prenatal Care

Health Net conducted two PDSA cycles to improve the MCP's performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure.

For the first PDSA cycle, Health Net's Member Retention Department conducted phone outreach to identified pregnant beneficiaries in Kern, San Diego, and San Joaquin counties to encourage timely prenatal care and assist the beneficiaries with making timely prenatal care appointments as needed. The MCP reporting learning that many of the beneficiaries called reported they had already scheduled or completed a timely prenatal visit, and no beneficiaries indicated plans to schedule a timely prenatal appointment or accepted assistance with making an appointment. Additionally, based on the proportion of beneficiaries with disconnected or wrong phone numbers, Health Net's quality improvement staff members planned to work with the MCP's Member Connections Team to conduct unannounced home visits to beneficiaries identified as pregnant who were not reached by the Member Retention Department.

For the second PDSA cycle, the MCP's Member Retention Department conducted phone outreach to identified pregnant beneficiaries in Kern, San Diego, and San Joaquin counties to encourage timely prenatal care and assist the beneficiaries with making timely prenatal care appointments as needed. The MCP's Member Connections Department conducted home visits for beneficiaries in San Joaquin County not reached by phone to encourage timely prenatal care, assist these beneficiaries with making timely prenatal care appointments as needed, and refer beneficiaries with high-risk pregnancies to case management. Health Net noted that the contact information for many beneficiaries was inaccurate. The MCP planned to expand the home visits to Kern County to increase the number of beneficiaries reached and improve the results of the intervention.

The rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure improved to above the minimum performance level in Kern, San Diego, and San Joaquin counties in reporting year 2019.

Care for Chronic Conditions

Table 3.29 through Table 3.35 present the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.29 through Table 3.35:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.29 through Table 3.35. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.29—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Health Net—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.62%	87.62%	88.03%	88.78%	0.75
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.49%	86.62%	87.74%	88.89%	1.15
*Asthma Medication Ratio^*	—	**50.82%**	**54.87%**	**51.04%**	-3.83
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	57.18%	54.99%	59.12%	62.53%	3.41
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**46.72%**	47.69%	49.15%	53.53%	4.38

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	43.80%	43.07%	51.82%	50.36%	-1.46
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	44.04%	45.26%	36.74%	35.77%	-0.97
*Comprehensive Diabetes Care—HbA1c Testing^*	**82.48%**	84.43%	85.40%	87.35%	1.95
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	89.54%	89.05%	90.51%	90.75%	0.24
Controlling High Blood Pressure	—	—	—	59.12%	Not Comparable

Table 3.30—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Health Net—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.83%	87.65%	88.11%	89.14%	1.03
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.16%	86.87%	87.73%	89.13%	1.40
*Asthma Medication Ratio^*	—	60.65%	61.66%	59.46%	-2.20
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	58.64%	61.31%	62.53%	63.26%	0.73
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	55.23%	63.02%	63.50%	65.94%	2.44
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	50.36%	50.36%	48.18%	54.01%	5.83

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	37.47%	40.15%	37.96%	33.58%	-4.38
*Comprehensive Diabetes Care—HbA1c Testing^*	85.64%	84.91%	87.10%	89.78%	2.68
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	91.48%	90.51%	92.70%	92.70%	0.00
Controlling High Blood Pressure	—	—	—	61.80%	Not Comparable

Table 3.31—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Health Net—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.68%	**82.87%**	**84.72%**	85.99%	1.27
Annual Monitoring for Patients on Persistent Medications—Diuretics	**84.46%**	**81.46%**	**84.15%**	**85.18%**	1.03
*Asthma Medication Ratio^*	—	60.98%	62.30%	61.28%	-1.02
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	57.18%	57.42%	55.72%	58.88%	3.16
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**35.04%**	**40.88%**	47.69%	55.47%	7.78
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	49.39%	45.26%	45.99%	51.09%	5.10

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	39.90%	41.12%	43.07%	37.71%	-5.36
*Comprehensive Diabetes Care—HbA1c Testing^*	**81.51%**	**78.35%**	**80.29%**	85.89%	5.60
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	90.27%	89.54%	89.78%	91.73%	1.95
Controlling High Blood Pressure	—	—	—	54.26%	Not Comparable

Table 3.32—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Health Net—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**82.48%**	86.18%	86.55%	89.63%	3.08
Annual Monitoring for Patients on Persistent Medications—Diuretics	**82.83%**	85.40%	87.82%	87.57%	-0.25
*Asthma Medication Ratio^*	—	64.15%	67.48%	65.53%	-1.95
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	62.77%	65.69%	67.64%	67.64%	0.00
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**46.72%**	57.91%	58.39%	64.48%	6.09
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	47.93%	49.64%	47.45%	54.01%	6.56

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	44.28%	37.23%	40.39%	34.31%	-6.08
*Comprehensive Diabetes Care—HbA1c Testing^*	**77.37%**	83.45%	**82.73%**	88.56%	5.83
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	87.83%	90.75%	90.27%	91.97%	1.70
Controlling High Blood Pressure	—	—	—	64.23%	Not Comparable

Table 3.33—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Health Net—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**83.81%**	**80.54%**	**83.40%**	87.10%	3.70
Annual Monitoring for Patients on Persistent Medications—Diuretics	**82.93%**	**81.45%**	**83.33%**	88.29%	4.96
*Asthma Medication Ratio^*	—	**46.55%**	61.11%	59.24%	-1.87
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	**47.45%**	52.31%	66.91%	63.99%	-2.92
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	53.28%	54.50%	61.80%	58.88%	-2.92
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	**39.90%**	41.12%	43.80%	45.74%	1.94

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	**50.85%**	49.39%	44.77%	43.31%	-1.46
*Comprehensive Diabetes Care—HbA1c Testing^*	**77.86%**	**73.97%**	**79.81%**	**81.75%**	1.94
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	89.05%	**83.21%**	**86.86%**	**86.37%**	-0.49
Controlling High Blood Pressure	—	—	—	58.64%	Not Comparable

Table 3.34—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Health Net—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**84.19%**	**83.64%**	**84.67%**	86.07%	1.40
Annual Monitoring for Patients on Persistent Medications—Diuretics	**83.98%**	**83.07%**	**84.26%**	87.05%	2.79
*Asthma Medication Ratio^*	—	60.33%	65.10%	62.59%	-2.51
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	59.61%	63.99%	62.53%	64.23%	1.70
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**44.28%**	**39.66%**	**36.25%**	51.34%	15.09
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	41.85%	52.31%	47.93%	52.55%	4.62

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	45.74%	38.93%	41.12%	37.23%	-3.89
*Comprehensive Diabetes Care—HbA1c Testing^*	**82.97%**	**81.75%**	85.40%	86.13%	0.73
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	88.08%	88.32%	88.56%	89.29%	0.73
Controlling High Blood Pressure	—	—	—	63.50%	Not Comparable

Table 3.35—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Health Net—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**84.52%**	86.31%	86.60%	86.60%	0.00
Annual Monitoring for Patients on Persistent Medications—Diuretics	**83.68%**	85.20%	86.02%	86.06%	0.04
*Asthma Medication Ratio^*	—	68.54%	71.16%	69.54%	-1.62
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	69.34%	66.67%	70.80%	66.91%	-3.89
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	51.09%	52.80%	57.66%	65.45%	7.79
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	44.04%	48.91%	48.42%	52.80%	4.38

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	43.80%	41.36%	40.15%	36.01%	-4.14
*Comprehensive Diabetes Care—HbA1c Testing^*	87.35%	85.40%	90.75%	93.19%	2.44
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	91.73%	89.29%	91.24%	91.73%	0.49
Controlling High Blood Pressure	—	—	—	59.85%	Not Comparable

Table 3.36 through Table 3.42 present findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.36 through Table 3.42:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.36—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—Kern County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	9	11.11%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	8	0.00%

Table 3.37—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—Los Angeles County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Table 3.38—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	3	66.67%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	9	11.11%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	8	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	6	0.00%

Table 3.39—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	8	0.00%

Table 3.40—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—San Joaquin County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	4	50.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	9	22.22%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	2	8	25.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.41—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—Stanislaus County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	3	3	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	6	0.00%

Table 3.42—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—Tulare County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	9	11.11%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Assessment of Corrective Action Plan—Care for Chronic Conditions

Based on reporting year 2018 performance measure results, DHCS required Health Net to conduct improvement activities for the following measures within the Care for Chronic Conditions domain as part of the MCP's CAP:

- Both *Annual Monitoring for Patients on Persistent Medications* measures in Sacramento, San Joaquin, and Stanislaus counties
- *Asthma Medication Ratio* in Kern County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Stanislaus County
- *Comprehensive Diabetes Care— HbA1c Testing* in Sacramento, San Diego, and San Joaquin counties
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in San Joaquin County

Asthma Medication Ratio

Health Net conducted two PDSA cycles to improve the MCP's performance for the *Asthma Medication Ratio* measure in Kern County. For both PDSA cycles, the MCP tested whether informing providers about changes to the QVAR inhaler affecting their patients' prescriptions and the expanded asthma controller medication fill benefit change from 30 days to 90 days would result in these providers issuing new prescriptions to their affected patients.

Health Net reported identifying the opportunity to survey providers to better determine whether they issued prescriptions as a result of the MCP outreach. Additionally, the MCP indicated that it would also be helpful to survey beneficiaries to better determine if prescriptions were issued but not filled and if other barriers exist for beneficiaries. Health Net indicated that to conduct the provider and beneficiary surveys, the MCP will need to recruit and train additional personnel.

The *Asthma Medication Ratio* measure rate remained below the minimum performance level in Kern County.

Annual Testing

DHCS approved Health Net to conduct one set of PDSA cycles to address the MCP's performance below the minimum performance levels for the *Annual Monitoring for Patients on Persistent Medications* and *Comprehensive Diabetes Care* measures included in the MCP's CAP.

For the first PDSA cycle, the MCP tested whether having a clinic partner conduct in-home services in Sacramento and San Joaquin counties would result in more beneficiaries completing their required annual testing related to the *Annual Monitoring for Patients on Persistent Medications* and *Comprehensive Diabetes Care* measures. The intervention provided the opportunity for beneficiaries who may have difficulty seeking care with their own providers to complete the required testing. Additionally, because the clinic partner faxed the beneficiaries' results to the beneficiaries' PCPs, the intervention provided continuity of care.

For the second PDSA cycle, Health Net tested the same intervention as in the first PDSA cycle; however, the MCP used beneficiary data to identify the ZIP codes in which the highest number of noncompliant beneficiaries resided to facilitate the most efficient outreach efforts.

After conducting both PDSA cycles, Health Net recognized the benefits of having the clinic partner serve as a liaison between the beneficiaries and providers and encouraging the beneficiaries to continue seeking regular care with their providers. Additionally, the providers were able to obtain baseline lab results for their patients, which aided them in providing optimum care. Finally, Health Net noted learning that it was important to maintain weekly meetings with the clinic partner to provide the opportunity to identify successes and work through barriers.

The reporting year 2019 performance measure results for the measures included in the annual testing PDSA cycles were as follows:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*:
  - The rates in Sacramento, San Joaquin, and Stanislaus counties improved to above the minimum performance level.
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
  - The rate in Stanislaus County improved significantly from reporting year 2018 to reporting year 2019, resulting in the rate moving to above the minimum performance level.
  - The rate in San Joaquin County improved from reporting year 2018 to reporting year 2019. Although the improvement was not statistically significant, the change resulted in the rate moving to above the minimum performance level in reporting year 2019.
  - The rate remained below the minimum performance level in Sacramento County.
- The *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure rate improved significantly from reporting year 2018 to reporting year 2019 in Stanislaus County, resulting in the rate moving to above the minimum performance level.
- *Comprehensive Diabetes Care—HbA1c Testing*
  - The rates in Sacramento and San Diego counties improved significantly from reporting year 2018 to reporting year 2019, resulting in the rates moving to above the minimum performance level in both counties.
  - The rate remained below the minimum performance level in San Joaquin County.
- The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate remained below the minimum performance level in San Joaquin County.

Appropriate Treatment and Utilization

Table 3.43 through Table 3.49 present the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.43 through Table 3.49:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.43—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Health Net—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	51.76	49.76	47.43	44.26	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	295.85	257.95	268.70	251.02	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	26.28%	28.15%	28.09%	33.52%	5.43
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	17.17%	Not Comparable
Use of Imaging Studies for Low Back Pain	**71.52%**	**61.09%**	70.53%	72.78%	2.25

Table 3.44—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Health Net—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	33.98	35.36	38.34	37.18	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	246.76	239.27	228.93	220.97	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	32.06%	29.99%	31.95%	33.93%	1.98
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	16.12%	Not Comparable
Use of Imaging Studies for Low Back Pain	75.62%	**68.94%**	76.09%	74.33%	-1.76

Table 3.45—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Health Net—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	50.27	50.46	51.44	50.33	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	206.66	217.25	212.52	229.08	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	30.57%	38.79%	43.75%	46.58%	2.83
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	15.69%	Not Comparable
Use of Imaging Studies for Low Back Pain	76.96%	70.46%	73.01%	72.90%	-0.11

Table 3.46—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Health Net—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	37.53	34.92	35.50	32.31	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	243.95	224.56	219.47	184.97	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	29.82%	34.15%	52.71%	50.43%	-2.28
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	21.25%	Not Comparable
Use of Imaging Studies for Low Back Pain	76.96%	**62.77%**	74.92%	67.60%	-7.32

Table 3.47—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Health Net—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	50.08	46.76	46.27	45.00	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	184.62	178.79	174.47	179.43	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	25.81%	**19.47%**	25.48%	29.37%	3.89
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	17.55%	Not Comparable
Use of Imaging Studies for Low Back Pain	75.60%	70.97%	79.37%	72.40%	-6.97

Table 3.48—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Health Net—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	58.30	56.01	54.36	51.42	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	279.85	256.42	232.13	221.22	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	29.04%	26.64%	34.56%	43.53%	8.97
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	14.59%	Not Comparable
Use of Imaging Studies for Low Back Pain	78.74%	70.98%	71.83%	73.65%	1.82

Table 3.49—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Health Net—Tulare County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	42.97	38.78	37.01	31.44	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	355.23	364.25	355.45	339.25	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	23.27%	26.71%	26.64%	28.73%	2.09
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	13.12%	Not Comparable
Use of Imaging Studies for Low Back Pain	81.41%	74.37%	78.47%	78.07%	-0.40

Table 3.50 through Table 3.56 present findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting

year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.50—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Health Net—Kern County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.51—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—Los Angeles County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.52—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—Sacramento County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	2	50.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.53—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—San Diego County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	2	50.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.54—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—San Joaquin County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.55—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—Stanislaus County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.56—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Health Net—Tulare County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.57 through Table 3.63 present a summary of Health Net's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.57 through Table 3.63:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.57—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Health Net—Kern County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	4	50.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	1	19	5.26%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	15	0.00%

Table 3.58—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Health Net—Los Angeles County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	4	19	21.05%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	19	5.26%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	1	19	5.26%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	18	0.00%

Table 3.59—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Health Net—Sacramento County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	19	5.26%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	19	15.79%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	4	6	66.67%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	13	0.00%

Table 3.60—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Health Net—San Diego County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	19	5.26%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	19	15.79%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	3	66.67%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	1	19	5.26%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	16	6.25%

Table 3.61—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Health Net—San Joaquin County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	4	9	44.44%
Reporting Year 2019 Rates Below Minimum Performance Levels	5	19	26.32%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	1	19	5.26%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	4	16	25.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	10	0.00%

Table 3.62—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Health Net—Stanislaus County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	5	19	26.32%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	5	6	83.33%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	19	5.26%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	13	0.00%

Table 3.63—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Health Net—Tulare County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	3	19	15.79%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	19	0.00%

Corrective Action Plan Requirements for 2019

Health Net's CAP will continue based on the MCP not achieving the CAP goals in reporting year 2019. Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, the following measures with rates below the minimum performance levels in reporting year 2019 will be included in Health Net's CAP:

- *Asthma Medication Ratio* in Kern County
- *Breast Cancer Screening* in San Diego and San Joaquin counties
- *Childhood Immunization Status—Combination 3* in Kern, Sacramento, San Diego, San Joaquin, and Stanislaus counties
- *Comprehensive Diabetes Care—HbA1c Testing* in San Joaquin County
- *Prenatal and Postpartum Care—Postpartum Care* in Los Angeles County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in San Joaquin County

The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate was below the minimum performance level in reporting year 2019 in San Joaquin County; however, DHCS will not include this measure in Health Net's 2019 CAP due to DHCS not requiring MCPs to report rates for this measure for reporting year 2020.

Additionally, while the rate was below the minimum performance level for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure in Sacramento County in reporting year 2019, DHCS will not require Health Net to conduct quality improvement activities for this measure as part of the MCP's CAP due to the small range of variation between the high performance level and minimum performance level thresholds for this measure.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.64 through Table 3.70 present the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.71 through Table 3.77 present the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.78 through Table 3.84 present the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.78 through Table 3.84.

Table 3.64—Multi-Year SPD Performance Measure Trend Table
Health Net—Kern County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	92.60	90.57	89.26	83.93	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	434.17	415.79	431.65	404.54	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.91%	86.57%	89.32%	90.35%	1.03
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.69%	86.26%	89.21%	92.68%	3.47
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	84.69%	80.50%	86.51%	81.65%	-4.86
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	81.37%	80.92%	82.63%	83.70%	1.07
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	73.61%	74.23%	80.77%	80.21%	-0.56
*Plan All-Cause Readmissions***	—	—	—	19.67%	Not Comparable

Table 3.65—Multi-Year SPD Performance Measure Trend Table
Health Net—Los Angeles County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	58.87	63.41	65.31	61.35	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	354.75	370.61	354.47	346.97	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.81%	89.37%	89.78%	90.71%	0.93
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.30%	89.29%	89.93%	91.19%	1.26
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	89.80%	NA	79.03%	84.00%	4.97
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	75.80%	81.32%	75.18%	76.23%	1.05
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	82.05%	84.29%	84.95%	84.07%	-0.88
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	74.12%	77.22%	78.35%	78.94%	0.59
*Plan All-Cause Readmissions***	—	—	—	23.62%	Not Comparable

Table 3.66—Multi-Year SPD Performance Measure Trend Table
Health Net—Sacramento County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	81.39	86.01	87.52	84.87	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	307.81	348.23	349.07	377.95	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.86%	85.63%	88.85%	88.62%	-0.23
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.27%	86.21%	88.08%	88.75%	0.67
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	76.47%	75.75%	75.35%	70.97%	-4.38
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	84.21%	85.19%	83.38%	83.33%	-0.05
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	74.77%	76.12%	75.72%	76.42%	0.70
*Plan All-Cause Readmissions***	—	—	—	20.56%	Not Comparable

Table 3.67—Multi-Year SPD Performance Measure Trend Table
Health Net—San Diego County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	70.36	71.66	70.50	64.34	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	297.18	306.41	294.72	257.80	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	84.19%	89.82%	86.40%	88.65%	2.25
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.73%	90.53%	89.67%	86.21%	-3.46
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	74.31%	84.80%	71.61%	71.63%	0.02
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	76.25%	80.20%	78.37%	79.69%	1.32
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	71.03%	70.83%	72.05%	74.43%	2.38
*Plan All-Cause Readmissions***	—	—	—	31.55%	Not Comparable

Table 3.68—Multi-Year SPD Performance Measure Trend Table
Health Net—San Joaquin County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	96.83	93.07	99.11	81.56	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	285.19	277.60	273.11	290.63	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.57%	81.15%	84.82%	87.61%	2.79
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.21%	82.35%	88.41%	90.91%	2.50
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	71.43%	51.52%	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA	78.13%	75.00%	85.00%	10.00
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	71.15%	75.36%	80.26%	75.27%	-4.99
*Plan All-Cause Readmissions***	—	—	—	27.40%	Not Comparable

Table 3.69—Multi-Year SPD Performance Measure Trend Table
Health Net—Stanislaus County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	92.88	96.15	91.07	83.83	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	404.61	392.14	367.23	360.57	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.13%	86.16%	87.90%	87.39%	-0.51
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.78%	87.45%	86.68%	89.07%	2.39
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.27%	83.76%	86.58%	89.62%	3.04
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	85.75%	85.88%	86.90%	89.32%	2.42
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.66%	84.18%	82.37%	82.62%	0.25
*Plan All-Cause Readmissions***	—	—	—	19.26%	Not Comparable

Table 3.70—Multi-Year SPD Performance Measure Trend Table
Health Net—Tulare County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	73.69	70.51	60.81	51.64	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	523.29	556.77	531.58	520.99	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.04%	90.65%	89.53%	88.59%	-0.94
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.99%	89.80%	89.96%	89.73%	-0.23
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	88.43%	88.92%	89.26%	92.00%	2.74
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.86%	92.26%	91.28%	93.56%	2.28
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.04%	90.41%	90.21%	92.88%	2.67
*Plan All-Cause Readmissions***	—	—	—	18.89%	Not Comparable

Table 3.71—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—Kern County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	48.03	46.43	44.21	41.18	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	283.20	245.08	256.16	239.07	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.02%	88.03%	87.60%	88.26%	0.66
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.38%	86.80%	87.09%	87.30%	0.21
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	87.97%	89.87%	89.16%	90.31%	1.15
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	78.73%	78.43%	78.75%	79.34%	0.59
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	75.03%	75.19%	76.92%	77.62%	0.70
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	75.49%	75.77%	76.91%	77.84%	0.93
*Plan All-Cause Readmissions***	—	—	—	15.92%	Not Comparable

Table 3.72—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—Los Angeles County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	32.07	33.51	36.51	35.60	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	238.49	230.62	220.39	212.74	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.43%	87.07%	87.52%	88.70%	1.18
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.18%	85.94%	86.85%	88.48%	1.63
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	88.03%	89.66%	89.97%	90.10%	0.13
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	78.42%	79.62%	80.87%	82.00%	1.13
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	84.24%	84.54%	85.35%	85.34%	-0.01
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	79.88%	80.38%	81.76%	82.41%	0.65
*Plan All-Cause Readmissions***	—	—	—	13.31%	Not Comparable

Table 3.73—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—Sacramento County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	46.88	47.02	48.04	47.03	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	195.65	204.57	199.67	214.86	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.21%	81.14%	82.26%	84.53%	2.27
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.65%	78.41%	81.74%	83.10%	1.36
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	88.58%	88.86%	91.17%	92.60%	1.43
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	76.60%	76.70%	79.13%	81.14%	2.01
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	80.76%	79.66%	80.83%	81.17%	0.34
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	77.39%	77.24%	77.92%	79.26%	1.34
*Plan All-Cause Readmissions***	—	—	—	12.57%	Not Comparable

Table 3.74—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—San Diego County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	34.85	32.75	33.51	30.63	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	239.61	219.72	215.18	181.15	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.12%	84.46%	86.60%	89.80%	3.20
Annual Monitoring for Patients on Persistent Medications—Diuretics	78.24%	82.68%	86.89%	87.86%	0.97
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	92.37%	90.95%	88.49%	88.67%	0.18
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	82.06%	82.97%	80.95%	80.59%	-0.36
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	87.32%	87.13%	86.64%	85.91%	-0.73
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.07%	83.29%	82.67%	83.41%	0.74
*Plan All-Cause Readmissions***	—	—	—	15.34%	Not Comparable

Table 3.75—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—San Joaquin County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	47.73	44.44	43.56	43.00	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	179.55	173.84	169.42	173.33	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.53%	80.42%	83.13%	86.99%	3.86
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.61%	81.25%	82.08%	87.68%	5.60
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	83.08%	85.49%	88.07%	85.43%	-2.64
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	66.85%	73.35%	75.45%	76.81%	1.36
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	74.74%	70.95%	71.26%	72.33%	1.07
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	73.00%	71.57%	72.00%	74.98%	2.98
*Plan All-Cause Readmissions***	—	—	—	14.41%	Not Comparable

Table 3.76—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—Stanislaus County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	55.19	52.72	51.58	48.99	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	268.61	245.27	221.90	210.78	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.66%	82.48%	83.37%	85.59%	2.22
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.47%	80.65%	83.18%	86.21%	3.03
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	90.13%	90.06%	89.15%	89.50%	0.35
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	81.56%	79.58%	78.44%	80.01%	1.57
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	84.61%	81.51%	80.83%	81.84%	1.01
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	80.47%	77.85%	77.16%	79.15%	1.99
*Plan All-Cause Readmissions***	—	—	—	12.52%	Not Comparable

Table 3.77—Multi-Year Non-SPD Performance Measure Trend Table
Health Net—Tulare County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	40.93	36.97	35.73	30.40	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	344.08	353.22	345.98	329.92	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.21%	85.02%	85.86%	86.12%	0.26
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.75%	83.75%	84.81%	84.99%	0.18
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.78%	94.68%	96.25%	96.97%	0.72
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.24%	88.39%	89.85%	90.07%	0.22
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.72%	89.66%	89.99%	90.93%	0.94
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.52%	87.39%	87.86%	89.19%	1.33
*Plan All-Cause Readmissions***	—	—	—	11.12%	Not Comparable

Table 3.78—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—Kern County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	83.93	41.18	Not Tested	44.26
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	404.54	239.07	Not Tested	251.02
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.35%	88.26%	2.09	88.78%
Annual Monitoring for Patients on Persistent Medications—Diuretics	92.68%	87.30%	5.38	88.89%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	90.31%	Not Comparable	90.35%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	81.65%	79.34%	2.31	79.37%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	83.70%	77.62%	6.08	77.80%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	80.21%	77.84%	2.37	77.93%
*Plan All-Cause Readmissions***	19.67%	15.92%	3.75	17.17%

Table 3.79—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—Los Angeles County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	61.35	35.60	Not Tested	37.18
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	346.97	212.74	Not Tested	220.97
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.71%	88.70%	2.01	89.14%
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.19%	88.48%	2.71	89.13%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	84.00%	90.10%	-6.10	90.08%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	76.23%	82.00%	-5.77	81.91%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	84.07%	85.34%	-1.27	85.29%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	78.94%	82.41%	-3.47	82.27%
*Plan All-Cause Readmissions***	23.62%	13.31%	10.31	16.12%

Table 3.80—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—Sacramento County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	84.87	47.03	Not Tested	50.33
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	377.95	214.86	Not Tested	229.08
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.62%	84.53%	4.09	85.99%
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.75%	83.10%	5.65	85.18%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	92.60%	Not Comparable	92.55%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	70.97%	81.14%	-10.17	80.99%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	83.33%	81.17%	2.16	81.24%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	76.42%	79.26%	-2.84	79.12%
*Plan All-Cause Readmissions***	20.56%	12.57%	7.99	15.69%

Table 3.81—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—San Diego County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	64.34	30.63	Not Tested	32.31
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	257.80	181.15	Not Tested	184.97
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.65%	89.80%	-1.15	89.63%
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.21%	87.86%	-1.65	87.57%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	88.67%	Not Comparable	88.60%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	71.63%	80.59%	-8.96	80.41%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	79.69%	85.91%	-6.22	85.69%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	74.43%	83.41%	-8.98	83.05%
*Plan All-Cause Readmissions***	31.55%	15.34%	16.21	21.25%

Table 3.82—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—San Joaquin County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	81.56	43.00	Not Tested	45.00
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	290.63	173.33	Not Tested	179.43
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.61%	86.99%	0.62	87.10%
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.91%	87.68%	3.23	88.29%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	85.43%	Not Comparable	85.49%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	NA	76.81%	Not Comparable	76.58%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	85.00%	72.33%	12.67	72.68%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	75.27%	74.98%	0.29	74.99%
*Plan All-Cause Readmissions***	27.40%	14.41%	12.99	17.55%

Table 3.83—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—Stanislaus County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	83.83	48.99	Not Tested	51.42
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	360.57	210.78	Not Tested	221.22
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.39%	85.59%	1.80	86.07%
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.07%	86.21%	2.86	87.05%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	89.50%	Not Comparable	89.58%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	89.62%	80.01%	9.61	80.16%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.32%	81.84%	7.48	82.10%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	82.62%	79.15%	3.47	79.32%
*Plan All-Cause Readmissions***	19.26%	12.52%	6.74	14.59%

Table 3.84—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—Tulare County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	51.64	30.40	Not Tested	31.44
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	520.99	329.92	Not Tested	339.25
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.59%	86.12%	2.47	86.60%
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.73%	84.99%	4.74	86.06%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	96.97%	Not Comparable	96.95%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	92.00%	90.07%	1.93	90.10%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	93.56%	90.93%	2.63	91.01%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	92.88%	89.19%	3.69	89.32%
*Plan All-Cause Readmissions***	18.89%	11.12%	7.77	13.12%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that Health Net stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 SPD rates were significantly better than the reporting year 2018 SPD rates for both *Annual Monitoring for Patients on Persistent Medications* measures in Los Angeles County.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the following measures:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Los Angeles, Sacramento, and San Diego counties
  - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Los Angeles County
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Los Angeles, Sacramento, and Stanislaus counties
  - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Tulare County
  - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Los Angeles, Sacramento, San Joaquin, Stanislaus, and Tulare counties
- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Los Angeles and Sacramento counties
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Kern, Los Angeles, Sacramento, and Tulare counties
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Stanislaus County
- *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Kern and Stanislaus counties
- *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Tulare County

- The reporting year 2019 SPD rates were significantly worse than the reporting year 2019 non-SPD rates for the following measures:
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Los Angeles, Sacramento, and San Diego counties
  - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in San Diego County
  - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Los Angeles and San Diego counties
  - *Plan All-Cause Readmissions* in all seven counties

  Note that the significant differences in rates for the *Children and Adolescents' Access to Primary Care Practitioners* measures may be attributed to beneficiaries in these age groups in the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from PCPs. Additionally, the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that Health Net followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for Health Net across all domains and reporting units:

- Tulare County had no rates below the minimum performance levels.
- The rates for the following measures were above the high performance levels:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in Sacramento and San Diego counties
  - *Comprehensive Diabetes Care—HbA1c Testing* in Tulare County

  - Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures in Tulare County. The rates for these measures were above the high performance levels for all four reporting years in Table 3.7.
- Nineteen of 133 rates (14 percent) improved significantly from reporting year 2018 to reporting year 2019.
- For measures for which DHCS held MCPs accountable to meet the minimum performance levels in reporting year 2018, 17 of 29 rates that were below the minimum performance levels in reporting year 2018 (59 percent) improved to above the minimum performance levels in reporting year 2019.

Opportunities for Improvement—Performance Measures

While the performance measure results and findings displayed in Table 3.1 through Table 3.84 reflect improvement across all domains and reporting units, Health Net continues to have opportunities for improvement based on 13 of 133 rates for which DHCS held MCPs accountable to meet the minimum performance levels in reporting year 2019 (10 percent) being below the minimum performance levels.

Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, Health Net continues to have opportunities for improvement for the following measures with rates below the minimum performance levels in reporting year 2019:

- *Asthma Medication Ratio* in Kern County
- *Breast Cancer Screening* in San Diego and San Joaquin counties
- *Childhood Immunization Status—Combination 3* in Kern, Sacramento, San Diego, San Joaquin, and Stanislaus counties
- *Comprehensive Diabetes Care—HbA1c Testing* in San Joaquin County
- *Prenatal and Postpartum Care—Postpartum Care* in Los Angeles County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in San Joaquin County

Health Net should determine which quality improvement strategies contributed to improvement from reporting year 2018 to reporting year 2019 and expand these successful strategies within the MCP, across counties, and in new provider sites, as applicable.

In addition to the measures listed previously with rates below the minimum performance levels in reporting year 2019, the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate in San Joaquin County was below the minimum performance level. While the MCP has opportunities for improvement related to this measure, HSAG makes no formal recommendations to the MCP because DHCS will not require MCPs to report the measure to DHCS in reporting year 2020, and DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCP's quality improvement actions related to the measure.

Finally, while the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure rate in Sacramento County also was below the minimum performance level in reporting year 2019, HSAG makes no formal recommendations to Health Net related to the measure. This is due to the small range of variation between the high performance level and minimum performance level thresholds for this measure.

DHCS and HSAG expect that Health Net will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCP will conduct improvement activities, as applicable, related to the *Annual Monitoring for Patients on Persistent Medications—Diuretics* and *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measures.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Health Net's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Health Net report rates for three HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 and Table 4.2 present the rates for each required MLTSSP performance measure for reporting years 2016 through 2019. The reporting year is the year in which the MLTSSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between reporting year 2018 and reporting year 2019. Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of those changes.

Table 4.1—Multi-Year MLTSSP Performance Measure Results
Health Net—Los Angeles County

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	68.53	79.59	83.14	73.21	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	549.24	671.23	672.91	659.86	Not Tested
Medication Reconciliation Post-Discharge	3.41%	8.03%	12.41%	32.36%	19.95

Table 4.2—Multi-Year MLTSSP Performance Measure Results
Health Net—San Diego County

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

S = Since there are fewer than 11 cases in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	87.67	91.57	91.07	66.74	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	635.00	570.74	606.92	472.62	Not Tested
Medication Reconciliation Post-Discharge	S	9.21%	19.55%	23.40%	3.85

Managed Long-Term Services and Supports Plan Performance Measure Findings

The *Medication Reconciliation Post-Discharge* measure rate improved significantly from reporting year 2018 to reporting year 2019 in Los Angeles County.

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, Health Net conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required Health Net to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, Health Net identified cervical cancer screening among Mandarin-speaking Chinese beneficiaries as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.1—Health Net *Cervical Cancer Screening* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of cervical cancer screening among Chinese beneficiaries ages 24 to 64 assigned to Provider Group A[6] whose preferred language is English or Mandarin.	56.1%	62.0%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated modules 1 through 3 for the MCP's *Cervical Cancer Screening* Disparity PIP. Upon initial review of the modules, HSAG determined that Health Net met all validation criteria for Module 1 in its initial submission; however, HSAG identified opportunities for improvement related to including all required components of the following in modules 2 and 3:

- SMART Aim measure
- SMART Aim data collection methodology
- Run/control chart
- FMEA table

[6] Provider group name removed for confidentiality.

After receiving technical assistance from HSAG, Health Net incorporated HSAG's feedback into modules 2 and 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for modules 2 and 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Cervical Cancer Screening* Disparity PIP, HSAG reviewed and provided feedback to Health Net on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Health Net that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.2 presents a description of the interventions that Health Net tested for its *Cervical Cancer Screening* Disparity PIP. The table also indicates the failure modes that each intervention addressed.

Table 5.2—Health Net *Cervical Cancer Screening* Disparity PIP Intervention Testing

Intervention	Failure Modes Addressed
Write a prescription for cervical cancer screening (in English and Chinese/Mandarin) for women to schedule an appointment for their cervical cancer screening.	♦ Cervical cancer screening is not a priority among Chinese women. ♦ Appointment availability for cervical cancer screening. ♦ Limited or no education about preventive screening for Chinese beneficiaries in the provider's office.
Provide an on-site beneficiary incentive at provider partner sites for cervical cancer screening completion.	♦ Beneficiaries must schedule another appointment with another provider other than their PCP to complete a cervical cancer screening.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Health Net to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although Health Net completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Health Net's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required Health Net to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, Health Net selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.3—Health Net *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate for the *Childhood Immunization Status—Combination 3* measure among beneficiaries who reside in Kern County and are assigned to Provide Group C[7]	58.76%	66.18%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the MCP's *Childhood Immunization Status—Combination 3* PIP. Upon initial review of the module, HSAG determined that Health Net met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Supporting the sub-processes selection for the FMEA table.
- Including all required components of the FMEA.
- Describing the priority-ranking process.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, Health Net incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

[7] Provider group name removed for confidentiality.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 3* PIP, HSAG reviewed and provided feedback to Health Net on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Health Net that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.4 presents a description of the intervention that Health Net tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the key driver and failure mode that the intervention addressed.

Table 5.4—Health Net *Childhood Immunization Status—Combination 3* PIP Intervention Testing

Intervention	Key Driver and Failure Mode Addressed
Offer a two-part immunization incentive to beneficiaries for being up to date at age 1 and for completing the vaccination series by age 2.	♦ Beneficiary engagement. ♦ Parents only value and keep certain appointments.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Health Net to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although Health Net completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Health Net's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, Health Net submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on Health Net's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

7. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[8] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

8. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with Health Net, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

9. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 9.1 provides EQR recommendations from Health Net's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 9.1 to preserve the accuracy of Health Net's self-reported actions.

Table 9.1—Health Net's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. To build on improvements already achieved, identify which strategies contributed to performance measure improvement from RY 2017 to RY 2018 and expand these successful strategies within the MCP and new provider sites, as applicable.	Health Net identified areas of achievement and expanded on successful strategies that improved low performance on measures. These strategies included member outreach campaigns, provider trainings, and care gap incentive programs through various approaches. In addition, with support of cross-functional teams, Health Net furthered its collaboration with providers and health care organizations to implement improvement activities addressing access to care issues for members. Interventions included the following: ♦ HEDIS live outreach calls to members for appointment scheduling and reminders. ♦ Member education campaigns on important health care topics. ♦ In-home member screening services. ♦ Member incentives for health care engagement. ♦ Collaborative projects with providers and vendors on access to care strategies: ■ Outreach to high-volume providers with high-risk members.

2017–18 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	■ Provider education and trainings by provider relations and practice transformation teams. ■ Mobile health care events including extended weekend clinics, mobile mammography events, and one-stop clinics with high-volume providers.
2. Continue monitoring interventions and outcomes to facilitate improvement beyond the life of the 2015–17 *Postpartum Care* and *Comprehensive Diabetes Care* PIPs.	Health Net continued to monitor interventions and outcomes to facilitate improvement beyond the life of the 2015–17 *Postpartum Care* and *Comprehensive Diabetes Care* PIPs. Health Net monitored interventions via: ♦ Periodic care gap and performance tracking reports. ♦ Evaluation of outcomes for the following interventions: ■ In-home visits and health assessments ■ Incentive programs ■ Member and provider outreach campaigns Health Net has also collaborated with DHCS in high-priority counties to complete a strengths, weaknesses, opportunities, and threats (SWOT) project that promotes greater innovation and takes a deeper look into the problems impacting perinatal care in the delivery system.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Health Net's self-reported actions in Table 9.1 and determined that Health Net adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. Health Net indicated that the MCP identified areas of achievement and expanded on successful strategies that resulted in improved performance. Health Net also described the mechanisms by which the MCP continued to monitor successful interventions from the 2015–17 *Postpartum Care* and *Comprehensive Diabetes Care* PIPs and reported that the MCP is collaborating with DHCS on a SWOT project in high-priority counties to address perinatal care in the delivery system. The MCP's quality improvement efforts as described in Table 9.1 may have contributed to the improvements noted in Section 3 of this report ("Managed Care Health Plan Performance Measures").

2018–19 Recommendations

Based on the overall assessment of Health Net's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to ensure that the MCP fully resolves all findings from the 2018 Medical and State Supported Services Audits.
- For the following measures, determine which quality improvement strategies contributed to improvement from reporting year 2018 to reporting year 2019 and expand these successful strategies within the MCP, across counties, and in new provider sites, as applicable:
  - *Asthma Medication Ratio* in Kern County
  - *Breast Cancer Screening* in San Diego and San Joaquin counties
  - *Childhood Immunization Status—Combination 3* in Kern, Sacramento, San Diego, San Joaquin, and Stanislaus counties
  - *Comprehensive Diabetes Care—HbA1c Testing* in San Joaquin County
  - *Prenatal and Postpartum Care—Postpartum Care* in Los Angeles County
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in San Joaquin County

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

Appendix Q:
Performance Evaluation Report
Health Net of California
July 1, 2018–June 30, 2019

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Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS' contracted Medi-Cal dental managed care (DMC) plan, Health Net of California ("Health Net" or "the DMC plan"). The purpose of this appendix is to provide DMC-specific results of each activity and an assessment of the DMC plan's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to dental care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as "beneficiaries" in this report). The review period for this DMC plan-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in Health Net's 2019–20 MCP-specific evaluation report. This DMC plan-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all managed care health plan (MCP), population-specific health plan (PSP), specialty health plan (SHP), and DMC plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCPs, PSPs, SHPs, and DMC plans are providing to beneficiaries.

Medi-Cal Dental Managed Care Plan Overview

Health Net operates in Los Angeles County as a Prepaid Health Plan (PHP) and in Sacramento County under a Geographic Managed Care (GMC) model. In Los Angeles County beneficiaries have the option of enrolling in a DMC plan or accessing dental benefits through the dental fee-for-service (FFS) delivery system, whereas in Sacramento County DMC enrollment is mandatory.

Health Net became operational as a DMC plan in Los Angeles County effective July 1, 2013, and in Sacramento County effective January 1, 2013. As of June 2019, Health Net had 173,246 beneficiaries in Los Angeles County and 127,147 in Sacramento County—for a total of 300,393 beneficiaries.[1] This represents 45 percent of the DMC beneficiaries enrolled in Los Angeles County and 30 percent of DMC beneficiaries enrolled in Sacramento County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Dental Managed Care Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Health Net. The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes results and status of the most recent Department of Managed Health Care (DMHC) Routine Survey of Health Net. DMHC conducted the initial on-site survey from February 23, 2016, through February 25, 2016, and subsequent desk-level follow-up survey on October 23, 2017, to assess the status of any findings that remained uncorrected at the time DMHC issued the final report. While DMHC conducted the on-site and desk-level follow-up surveys outside the review period for this DMC plan-specific evaluation report, HSAG includes the information because these are the most recent surveys conducted by DMHC.

Table 2.1—2016 DMHC Routine Survey of Health Net

Category Evaluated	Deficiencies/ Findings (Yes/No)	Monitoring Status
Section I: Knox-Keene Survey		
Quality Management	No	Not applicable.
Grievances and Appeals	Yes	Corrected.
Access and Availability of Services	No	Not applicable.
Utilization Management	No	Not applicable.
Language Assistance	Yes	Corrected.
Section II: Medi-Cal Dental Managed Care Survey		
Access and Availability	No	Not applicable.
Grievance and Appeals Policy and Procedures	No	Not applicable.
Quality Management	No	Not applicable.
Utilization Management	No	Not applicable.

Strengths—Compliance Reviews

DMHC identified no findings in seven of the nine categories evaluated during the February 2016 Routine Survey of Health Net.

Opportunities for Improvement—Compliance Reviews

Health Net has no outstanding findings from the February 2016 DMHC Routine Survey or October 2017 desk-level follow-up survey; therefore, HSAG has no recommendations for the DMC plan in the area of compliance reviews.

3. Dental Managed Care Plan Performance Measures

DHCS requires DMC plans to submit quarterly self-reported performance measure rates for each reporting unit (i.e., Los Angeles County and Sacramento County). To provide ongoing, consistent comparison over time, DMC plans use a rolling 12-month methodology to display rates for a full year within each quarterly performance measure rate report.

Reporting year 2019 was the first year that DHCS required DMC plans to submit both reporting units' audited performance measure rates reflecting measurement year (MY) data from the previous calendar year. In April 2019, Health Net submitted both reporting units' reporting year 2019 performance measure rates reflecting measurement year 2018 data (i.e., January 1, 2018, through December 31, 2018).

Performance Measure Results

Table 3.1 and Table 3.2 present Health Net's reporting year 2019 audited performance measure rates for each DMC plan reporting unit. To allow HSAG to provide a meaningful display of DMC plan performance, HSAG organized the performance measures according to the health care areas that each measure affects (i.e., Access to Care and Preventive Care).

Note that HSAG could not compare reporting year 2019 DMC plan performance measure rates to historical data or DHCS' encounter data since reporting year 2019 was the first year that DMC plans were required to report audited performance measure rates; therefore, HSAG makes no conclusions or recommendations related to DMC plans' reporting year 2019 performance measure results.

Table 3.1—Reporting Year 2019 (Measurement Year 2018) Dental Managed Care Plan Performance Measure Results
Health Net—Los Angeles County

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Measure	Reporting Year 2019 Rate
Access to Care	
Annual Dental Visits—0–20 Years	38.0%
Annual Dental Visits—21+ Years	19.2%
Continuity of Care—0–20 Years	64.2%
Continuity of Care—21+ Years	34.7%

Measure	Reporting Year 2019 Rate
Exam/Oral Health Evaluations—0–20 Years	33.7%
Exam/Oral Health Evaluations—21+ Years	15.3%
General Anesthesia—0–20 Years	41.2%
General Anesthesia—21+ Years	31.2%
Overall Utilization of Dental Services–One Year—0–20 Years	42.9%
Overall Utilization of Dental Services–One Year—21+ Years	19.5%
Use of Dental Treatment Services—0–20 Years	17.1%
Use of Dental Treatment Services—21+ Years	11.6%
Usual Source of Care—0–20 Years	32.9%
Usual Source of Care—21+ Years	8.9%
Preventive Care	
Preventive Services to Filling—0–20 Years	80.5%
Preventive Services to Filling—21+ Years	26.1%
Sealants to Restoration Ratio (Surfaces)—6–9 Years	6.1
Sealants to Restoration Ratio (Surfaces)—10–14 Years	2.7
Treatment/Prevention of Caries—0–20 Years	24.2%
Treatment/Prevention of Caries—21+ Years	6.1%
Use of Preventive Services—0–20 Years	32.3%
Use of Preventive Services—21+ Years	7.7%
Use of Sealants—6–9 Years	13.6%
Use of Sealants—10–14 Years	5.8%

Table 3.2—Reporting Year 2019 (Measurement Year 2018) Dental Managed Care Plan Performance Measure Results
Health Net—Sacramento County

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Measure	Reporting Year 2019 Rate
Access to Care	
Annual Dental Visits—0–20 Years	37.4%
Annual Dental Visits—21+ Years	19.4%
Continuity of Care—0–20 Years	67.5%
Continuity of Care—21+ Years	36.5%
Exam/Oral Health Evaluations—0–20 Years	33.2%
Exam/Oral Health Evaluations—21+ Years	14.4%
General Anesthesia—0–20 Years	67.2%
General Anesthesia—21+ Years	26.7%
Overall Utilization of Dental Services–One Year—0–20 Years	45.3%
Overall Utilization of Dental Services–One Year—21+ Years	22.1%
Use of Dental Treatment Services—0–20 Years	21.4%
Use of Dental Treatment Services—21+ Years	13.3%
Usual Source of Care—0–20 Years	34.0%
Usual Source of Care—21+ Years	11.2%
Preventive Care	
Preventive Services to Filling—0–20 Years	83.5%
Preventive Services to Filling—21+ Years	36.9%
Sealants to Restoration Ratio (Surfaces)—6–9 Years	5.4
Sealants to Restoration Ratio (Surfaces)—10–14 Years	2.2
Treatment/Prevention of Caries—0–20 Years	28.2%
Treatment/Prevention of Caries—21+ Years	7.7%
Use of Preventive Services—0–20 Years	32.5%
Use of Preventive Services—21+ Years	8.2%
Use of Sealants—6–9 Years	14.1%
Use of Sealants—10–14 Years	6.9%

4. Performance Improvement Projects

DHCS requires DMC plans to conduct two quality improvement projects (QIPs) per year. DMC plans must participate in a DHCS-established and facilitated statewide QIP as well as an individual QIP that aligns with a demonstrated area in need of improvement.

Prior to January 2019, DHCS required DMC plans to submit quarterly progress reports for both the statewide and individual QIPs. After discussions with HSAG in January and February of 2019, DHCS modified the requirements for DMC plans. Beginning in February 2019, DHCS required DMC plans to submit two reports annually for the statewide QIP—one intervention progress report to HSAG, and an annual QIP submission to DHCS. Additionally, DHCS required DMC plans to begin conducting their individual QIPs using HSAG's rapid-cycle PIP process. With the transition of DMC plans' individual QIPs to HSAG's rapid-cycle PIP process, HSAG began referring to DMC plans' individual QIPs as individual performance improvement projects (PIPs).

Statewide Quality Improvement Project

DHCS requires DMC plans to conduct statewide QIPs focused on *Preventive Services Utilization*. The goals of the statewide QIP are to increase preventive services among children ages 1 to 20 by 10 percentage points by the end of 2023.

Based on the new reporting requirements, Health Net participated in HSAG's Statewide QIP Intervention Progress Report Overview webinar in March 2019 to obtain information on the report submission requirements. Health Net submitted the health plan's first intervention progress report to HSAG in April 2019. The DMC plan reported on identified barriers and interventions conducted as of March 31, 2019. In May 2019, HSAG provided feedback to Health Net on the intervention progress report, including the following:

- Health Net provided a key driver diagram, a description of the DMC plan's causal barrier processes and rankings, and intervention implementation and evaluation information.
- The DMC plan should rank the barriers in order of priority and revisit the casual/barrier analysis and priority ranking process at least annually.
- The DMC plan logically linked the interventions to identified barriers and implemented the interventions in a timely manner to directly impact study indicator outcomes.
- The DMC plan provided next steps for the intervention based on intervention evaluation data.

Individual Performance Improvement Project

Based on DHCS' new requirements, the DMC plan began to conduct its individual PIP using HSAG's rapid-cycle PIP process. Health Net selected dental care among beneficiaries living with diabetes as its individual PIP topic. In April 2019, Health Net participated in HSAG's rapid-cycle PIP process overview training session to obtain general background about the key concepts of the rapid-cycle PIP framework as well as submission requirements for modules 1 through 5 and HSAG's PIP validation process.

During the review period for this DMC-specific evaluation report, Health Net did not progress to submitting any PIP modules for HSAG to validate. Therefore, HSAG includes no validation findings in this report. HSAG will include a summary of the DMC plan's *Dental Care among Beneficiaries Living with Diabetes* PIP activities and validation findings in Health Net's 2019–20 DMC-specific evaluation report.

Strengths—Performance Improvement Projects

Health Net successfully completed the first intervention progress report for the *Preventive Services Utilization* statewide QIP, providing all requested information. The DMC plan also provided all required information to support its *Dental Care among Beneficiaries Living with Diabetes* individual PIP topic selection.

Opportunities for Improvement—Performance Improvement Projects

Based on Health Net's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Recommendations

Based on the overall assessment of Health Net's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the DMC plan.

In the next annual review, HSAG will evaluate continued successes of Health Net.

Appendix R:
Performance Evaluation Report
Health Plan of San Joaquin
July 1, 2018–June 30, 2019

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Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Health Plan of San Joaquin ("HPSJ" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in HPSJ's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

HPSJ is a full-scope MCP delivering services to beneficiaries as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in HPSJ, the Local Initiative MCP; or in Health Net Community Solutions, Inc., the alternative commercial plan.

HPSJ became operational in San Joaquin County to provide MCMC services effective February 1996 and in Stanislaus County effective January 2013. As of June 2019, HPSJ had 211,194 beneficiaries in San Joaquin County and 128,006 in Stanislaus County—for a total of 339,200 beneficiaries.[1] This represents 91 percent of the beneficiaries enrolled in San Joaquin County and 67 percent in Stanislaus County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for HPSJ. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of HPSJ. A&I conducted the audits from August 13, 2018, through August 23, 2018.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of HPSJ
Audit Review Period: July 1, 2017, through June 30, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	No	No findings.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	No	No findings.
Administrative and Organizational Capacity	Yes	CAP imposed and findings in this category rectified.
State Supported Services	No	No findings.

Follow-Up on 2017 A&I Medical Audit

A&I conducted Medical and State Supported Services Audits of HPSJ from July 31, 2017, through August 9, 2017, covering the review period of July 1, 2016, through June 30, 2017. HSAG provided a summary of the audit results and status in HPSJ's 2017–18 MCP-specific evaluation report. At the time of the 2017–18 MCP-specific evaluation report publication, HPSJ's CAP was in progress and under review by DHCS. A letter from DHCS dated July 18, 2018, stated that HPSJ provided DHCS with additional information regarding the CAP and that DHCS had found all items to be in compliance; therefore, DHCS closed the CAP.

Strengths—Compliance Reviews

A&I identified findings in only two categories during the August 2018 Medical and State Supported Services Audits of HPSJ. The MCP fully resolved the findings, resulting in DHCS closing the CAP. Additionally, HPSJ fully resolved the findings in the Case Management and Coordination of Care category from the 2017 A&I Medical and State Supported Services Audits.

Opportunities for Improvement—Compliance Reviews

HPSJ has no outstanding findings from the 2017 and 2018 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for Health Plan of San Joaquin* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that HPSJ followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.18 for HPSJ's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.18:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.16 present the performance measure results and findings by domain, and Table 3.17 and Table 3.18 present the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.
- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 and Table 3.2 present the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1 and Table 3.2:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
HPSJ—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	67.40%	**60.58%**	**55.23%**	70.56%	15.33
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	95.39%	95.10%	94.74%	95.20%	0.46

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**84.62%**	84.89%	85.77%	86.21%	0.44
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**86.87%**	**86.09%**	**86.37%**	**87.04%**	0.67
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**83.70%**	**81.94%**	**83.35%**	**84.14%**	0.79
Immunizations for Adolescents—Combination 2	—	21.65%	31.14%	39.42%	8.28
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	54.01%	60.10%	65.45%	76.40%	10.95

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	53.28%	55.23%	60.83%	72.75%	11.92
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.56%	72.51%	74.94%	70.80%	-4.14

Table 3.2—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
HPSJ—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**62.53%**	**57.18%**	**58.64%**	66.18%	7.54
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**92.75%**	**92.37%**	**93.00%**	94.25%	1.25
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**83.11%**	**82.62%**	**82.95%**	**83.45%**	0.50
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**86.63%**	**84.48%**	**84.42%**	**85.55%**	1.13
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**83.32%**	**80.09%**	**79.82%**	**81.71%**	1.89
Immunizations for Adolescents—Combination 2	—	19.46%	22.87%	27.98%	5.11
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	**48.18%**	54.26%	60.83%	**52.55%**	-8.28

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	**43.07%**	47.45%	60.10%	**37.96%**	-22.14
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**57.18%**	**60.83%**	**62.53%**	67.40%	4.87

Table 3.3 and Table 3.4 present findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.3 and Table 3.4:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.3—Preventive Screening and Children's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
HPSJ—San Joaquin County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	4	5	80.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	4	0.00%

Table 3.4—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings HPSJ—Stanislaus County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	2	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	5	40.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	5	40.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	3	66.67%

Assessment of Corrective Action Plan—Preventive Screening and Children's Health

Based on reporting year 2018 performance measure results, DHCS required HPSJ to conduct improvement activities for the following measures within the Preventive Screening and Children's Health domain that are included in the MCP's CAP:

- *Childhood Immunization Status—Combination 3* for both reporting units
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Stanislaus County

Childhood Immunizations

The rates were below the minimum performance level for the *Childhood Immunization Status—Combination 3* measure for both reporting units in reporting year 2018; however, because DHCS had already approved HPSJ to conduct a PIP to address the MCP's continued performance below the minimum performance level for the *Childhood Immunization Status—Combination 3* measure, DHCS did not require the MCP to conduct additional quality improvement activities related to this measure. HSAG includes a summary of HPSJ's progress on the *Childhood Immunization Status—Combination 3* PIP in Section 4 of this report ("Performance Improvement Projects").

The rates for the *Childhood Immunization Status—Combination 3* measure in both reporting units improved significantly from reporting year 2018 to reporting year 2019, resulting in the rates moving to above the minimum performance level in reporting year 2019.

Well-Child Visits

HPSJ conducted two PDSA cycles to help improve the MCP's performance to above the minimum performance level in Stanislaus County for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure.

For the first PDSA cycle, HPSJ tested whether conducting an educational data reconciliation process for a high-volume provider in Stanislaus County using electronic health records and claims data would increase the number of beneficiaries compliant with their well-child visits. The MCP reported that the intervention increased the number of beneficiaries seen for their well-child visits.

For the second PDSA cycle, HPSJ's population outreach team tested whether conducting a beneficiary outreach campaign using a standardized script and offering transportation assistance would increase the number of beneficiaries compliant with their well-child visits. The MCP reported learning that helping providers conduct beneficiary outreach using a standardized script; providing appointment reminders; and offering transportation, scheduling, and other care-related assistance results in more beneficiaries being seen for their well-child visits.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure moved to above the minimum performance level in Stanislaus County in reporting year 2019.

Preventive Screening and Women's Health

Table 3.5 and Table 3.6 present the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.5 and Table 3.6:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.5—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
HPSJ—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**51.67%**	**43.66%**	54.15%	10.49
Cervical Cancer Screening	**49.39%**	**47.20%**	55.72%	**54.01%**	-1.71
Prenatal and Postpartum Care—Postpartum Care	**45.99%**	61.80%	67.88%	68.61%	0.73
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**56.69%**	75.91%	80.78%	85.64%	4.86

Table 3.6—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
HPSJ—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	55.82%	**49.84%**	58.63%	8.79
Cervical Cancer Screening	**45.74%**	50.36%	53.04%	55.23%	2.19
Prenatal and Postpartum Care—Postpartum Care	**47.07%**	60.58%	60.83%	67.64%	6.81
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**64.15%**	75.67%	**76.40%**	86.37%	9.97

Table 3.7 and Table 3.8 present findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.7 and Table 3.8:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.7—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings HPSJ—San Joaquin County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.8—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings HPSJ—Stanislaus County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	3	100.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	2	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	1	0.00%

Assessment of Corrective Action Plan—Preventive Screening and Women's Health

Based on reporting year 2018 performance measure results, DHCS required HPSJ to conduct IPs for the following measures:

- *Breast Cancer Screening* in both reporting units
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Stanislaus County

Breast Cancer Screening

DHCS required HPSJ to submit a Pilot Quality Improvement Strategy Summary/Progress Report that described the quality improvement strategies the MCP implemented to address its performance below the minimum performance level in reporting year 2018 for the *Breast Cancer Screening* measure in both reporting units.

HPSJ indicated that the MCP implemented structured, multidisciplinary strategies to improve the rates for the *Breast Cancer Screening* measure in both reporting units. Interventions included beneficiary education, an incentive program, and a beneficiary outreach campaign using a family-based approach that included photoshoots and personal testimonials. HPSJ targeted low-performing providers and conducted gap-in-care report monitoring and follow-up education, posted breast cancer screening practice guidelines, conducted after-hour clinic days, and improved the breast cancer screening referral workflow. Additionally, HPSJ developed partnerships with the Every Woman Counts program and Susan G. Komen Breast Cancer Foundation for outreach and screening.

The rates for the *Breast Cancer Screening* measure in both reporting units improved significantly from reporting year 2018 to reporting year 2019, resulting in the rates moving to above the minimum performance level in reporting year 2019.

Timeliness of Prenatal Care

HPSJ conducted two PDSA cycles to help improve the MCP's performance to above the minimum performance level in Stanislaus County for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure. For both PDSA cycles, the MCP tested whether conducting outreach to pregnant eligible beneficiaries using a structured script to offer transportation and scheduling assistance would increase the number of beneficiaries compliant with their prenatal care visits. HPSJ reported learning that conducting outreach calls using a structured call plan and triaging low- to moderate-risk pregnant beneficiaries is a successful approach. Additionally, the MCP reported learning that a successful approach for high-risk beneficiaries is having the MCP's case management staff members responsible for conducting the outreach.

The rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure in Stanislaus County improved significantly from reporting year 2018 to reporting year 2019, resulting in the rate moving to above the minimum performance level in reporting year 2019.

Care for Chronic Conditions

Table 3.9 and Table 3.10 present the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.9 and Table 3.10:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.9 and Table 3.10. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.9—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
HPSJ—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**83.66%**	**83.83%**	**84.89%**	87.44%	2.55

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**83.75%**	**82.42%**	85.60%	87.42%	1.82
*Asthma Medication Ratio^*	—	57.59%	58.68%	**55.97%**	-2.71
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	**51.34%**	54.99%	58.15%	59.12%	0.97
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**41.85%**	**40.88%**	57.42%	60.83%	3.41
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	46.96%	45.26%	52.07%	50.36%	-1.71
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	45.01%	46.23%	38.44%	40.39%	1.95
*Comprehensive Diabetes Care—HbA1c Testing^*	**76.89%**	**81.51%**	**82.00%**	**80.05%**	-1.95
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	87.10%	90.27%	**84.91%**	**86.86%**	1.95
Controlling High Blood Pressure	—	—	—	64.48%	Not Comparable

Table 3.10—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
HPSJ—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**84.86%**	**84.58%**	**85.06%**	87.24%	2.18

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.22%	**85.14%**	**85.34%**	86.91%	1.57
*Asthma Medication Ratio^*	—	62.36%	64.92%	59.58%	-5.34
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	72.26%	66.67%	63.75%	62.04%	-1.71
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**44.53%**	**26.52%**	**45.01%**	50.85%	5.84
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	50.12%	54.74%	51.09%	54.50%	3.41
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	39.90%	35.04%	40.15%	35.77%	-4.38
*Comprehensive Diabetes Care—HbA1c Testing^*	**81.02%**	84.18%	**81.51%**	86.62%	5.11
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	87.35%	**85.16%**	**85.64%**	88.56%	2.92
Controlling High Blood Pressure	—	—	—	64.96%	Not Comparable

Table 3.11 and Table 3.12 present findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.11 and Table 3.12:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.11—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
HPSJ—San Joaquin County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	3	33.33%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	9	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	8	12.50%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	6	16.67%

Table 3.12—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
HPSJ—Stanislaus County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	5	5	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	4	0.00%

Assessment of Corrective Acton Plan—Care for Chronic Conditions

Based on reporting year 2018 performance measure results, DHCS required HPSJ to conduct improvement activities for the following measures within the Care for Chronic Conditions domain that are included in the MCP's CAP:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in both reporting units
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Stanislaus County
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Stanislaus County
- *Comprehensive Diabetes Care— HbA1c Testing* in both reporting units
- *Comprehensive Diabetes Care— Medical Attention for Nephropathy* in both reporting units

Lab Test Compliance

DHCS required HPSJ to submit a Pilot Quality Improvement Strategy Summary/Progress Report that described the quality improvement strategies the MCP implemented to address its performance below the minimum performance levels in reporting year 2018 for the following measures:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in both reporting units
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Stanislaus County
- *Comprehensive Diabetes Care— HbA1c Testing* in both reporting units
- *Comprehensive Diabetes Care— Medical Attention for Nephropathy* in both reporting units

DHCS allowed HPSJ to submit one Pilot Quality Improvement Strategy Summary/Progress Report describing the MCP's efforts to improve beneficiary compliance with recommended lab screenings.

HPSJ indicated that the MCP conducted provider trainings about how to access, analyze, and use gap-in-care reports and data. The MCP worked with providers to develop actionable

workplans that the MCP and providers routinely evaluated to help increase the percentage of beneficiaries who complete their recommended lab tests. HPSJ noted that a few of the targeted providers found success with implementing extended-hour clinics on Thursdays, in addition to having point-in-care contacts work to reduce the number of beneficiaries listed in the gap-in-care reports. HPSJ offered gift card incentives to beneficiaries immediately following their completion of a lab screening during the Thursday clinic days. HPSJ reported learning that conducting consistent interventions with targeted providers results in improved rates.

In addition to working with providers, HPSJ's outreach team conducted scripted calls to beneficiaries to offer help with lab location referrals, screening appointments, and transportation. The MCP reported that the beneficiary outreach calls were successful based on the number of beneficiaries reached who subsequently completed their lab screenings.

The rates for the following measures included in the Pilot Quality Improvement Strategy Summary/Progress Report improved to above the minimum performance levels in reporting year 2019:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in both reporting units
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Stanislaus County
- *Comprehensive Diabetes Care— HbA1c Testing* in Stanislaus County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Stanislaus County

The rates for the following measures included in the Pilot Quality Improvement Strategy Summary/Progress Report remained below the minimum performance levels in reporting year 2019 in San Joaquin County:

- *Comprehensive Diabetes Care— HbA1c Testing*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

DHCS required HPSJ to conduct PDSA cycles to improve the MCP's performance for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure in Stanislaus County. HPSJ conducted two PDSA cycles to improve the MCP's performance on this measure in Stanislaus County.

For both PDSA cycles, HPSJ partnered with two clinics in Stanislaus County to conduct beneficiary outreach. For the first PDSA cycle, HPSJ tested whether offering a recognition reward to the clinic that conducted outreach to the most beneficiaries would result in more beneficiaries being reached. For the second PDSA cycle, HPSJ supplemented the clinic outreach calls with standardized scripted calls conducted by the MCP's population outreach team. HPSJ reported learning that scripted outreach calls along with the timely addition of a mobile retinal eye exam clinic helped to improve the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure.

The rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure improved to above the minimum performance level in reporting year 2019 in Stanislaus County.

Appropriate Treatment and Utilization

Table 3.13 and Table 3.14 present the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.13 and Table 3.14:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level

or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.13—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
HPSJ—San Joaquin County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	48.82	49.82	49.03	48.63	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	244.43	234.67	247.86	270.48	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	26.08%	**18.23%**	25.95%	**21.78%**	-4.17
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	S	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	12.79%	Not Comparable
Use of Imaging Studies for Low Back Pain	81.04%	71.57%	75.91%	73.73%	-2.18

Table 3.14—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
HPSJ—Stanislaus County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	59.55	55.89	55.95	54.35	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	262.80	257.58	272.76	273.79	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	23.07%	26.25%	31.94%	34.30%	2.36
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	S	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	11.92%	Not Comparable
Use of Imaging Studies for Low Back Pain	78.15%	70.31%	73.25%	72.71%	-0.54

Table 3.15 and Table 3.16 present findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.15—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings HPSJ—San Joaquin County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	2	50.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	2	50.00%

Table 3.16—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings HPSJ—Stanislaus County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.17 and Table 3.18 present a summary of HPSJ's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.17 and Table 3.18:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.17—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
HPSJ—San Joaquin County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	7	19	36.84%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	3	5	60.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	4	19	21.05%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	1	19	5.26%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	14	14.29%

Table 3.18—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
HPSJ—Stanislaus County

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

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	6	19	31.58%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	9	9	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	3	19	15.79%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	10	20.00%

Corrective Action Plan Requirements for 2019

At the time HSAG produced this MCP-specific evaluation report, HPSJ remained on a quality CAP. Based on reporting year 2019 performance results and DHCS' decisions regarding reporting year 2020 performance measure requirements, the following measures with rates below the minimum performance levels in reporting year 2019 will be included in the CAP for San Joaquin County:

- *Asthma Medication Ratio*
- *Comprehensive Diabetes Care—HbA1c Testing*

The rates for the following measures were below the minimum performance levels in reporting year 2019; however, DHCS will not include these measures in HPSJ's CAP due to DHCS not requiring MCPs to report rates for these measures to DHCS for reporting year 2020:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Joaquin County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in San Joaquin County
- Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures in Stanislaus County

Seniors and Persons with Disabilities Performance Measure Results

Table 3.19 and Table 3.20 present the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.21 and Table 3.22 present the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.23 and Table 3.24 present the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.23 and Table 3.24.

Table 3.19—Multi-Year SPD Performance Measure Trend Table
HPSJ—San Joaquin County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	76.82	81.78	73.53	84.42	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	410.40	414.33	378.25	448.33	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.39%	85.24%	87.09%	88.80%	1.71
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.99%	85.68%	88.38%	89.39%	1.01
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.12%	95.35%	92.86%	100.00%	7.14
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.07%	88.26%	85.32%	87.31%	1.99
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	87.47%	87.15%	88.21%	88.39%	0.18
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.42%	82.97%	84.85%	85.64%	0.79
*Plan All-Cause Readmissions***	—	—	—	18.13%	Not Comparable

Table 3.20—Multi-Year SPD Performance Measure Trend Table
HPSJ—Stanislaus County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	109.30	105.98	92.32	96.59	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	508.87	513.61	487.97	551.04	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.73%	89.69%	89.73%	90.41%	0.68
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.32%	89.81%	89.94%	91.69%	1.75
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	81.71%	85.71%	87.76%	93.22%	5.46
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.30%	88.27%	89.73%	92.59%	2.86
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.66%	84.45%	85.46%	87.33%	1.87
*Plan All-Cause Readmissions***	—	—	—	17.23%	Not Comparable

Table 3.21—Multi-Year Non-SPD Performance Measure Trend Table
HPSJ—San Joaquin County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	46.52	47.11	46.11	45.81	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	230.79	219.42	232.33	256.47	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.81%	83.16%	83.78%	86.76%	2.98
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.94%	80.70%	84.03%	86.37%	2.34
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	95.40%	95.10%	94.76%	95.17%	0.41
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	84.59%	84.79%	85.79%	86.19%	0.40
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.84%	86.05%	86.30%	86.99%	0.69
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	83.66%	81.89%	83.29%	84.08%	0.79
*Plan All-Cause Readmissions***	—	—	—	9.87%	Not Comparable

Table 3.22—Multi-Year Non-SPD Performance Measure Trend Table
HPSJ—Stanislaus County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	56.58	52.86	53.03	51.82	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	248.12	242.12	255.47	257.23	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.93%	82.92%	83.51%	86.19%	2.68
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.01%	83.45%	83.57%	84.93%	1.36
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	92.72%	92.35%	92.95%	94.21%	1.26
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.13%	82.55%	82.85%	83.24%	0.39
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.55%	84.36%	84.24%	85.34%	1.10
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	83.28%	79.95%	79.64%	81.54%	1.90
*Plan All-Cause Readmissions***	—	—	—	9.88%	Not Comparable

Table 3.23—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations HPSJ—San Joaquin County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	84.42	45.81	Not Tested	48.63
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	448.33	256.47	Not Tested	270.48
Annual Monitoring for Patients on Persistent Medications— ACE Inhibitors or ARBs	88.80%	86.76%	2.04	87.44%
Annual Monitoring for Patients on Persistent Medications— Diuretics	89.39%	86.37%	3.02	87.42%
Children and Adolescents' Access to Primary Care Practitioners— 12–24 Months	100.00%	95.17%	4.83	95.20%
Children and Adolescents' Access to Primary Care Practitioners— 25 Months–6 Years	87.31%	86.19%	1.12	86.21%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	88.39%	86.99%	1.40	87.04%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	85.64%	84.08%	1.56	84.14%
*Plan All-Cause Readmissions***	18.13%	9.87%	8.26	12.79%

Table 3.24—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations HPSJ—Stanislaus County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	96.59	51.82	Not Tested	54.35
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	551.04	257.23	Not Tested	273.79
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.41%	86.19%	4.22	87.24%
Annual Monitoring for Patients on Persistent Medications— Diuretics	91.69%	84.93%	6.76	86.91%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	94.21%	Not Comparable	94.25%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	93.22%	83.24%	9.98	83.45%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	92.59%	85.34%	7.25	85.55%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.33%	81.54%	5.79	81.71%
*Plan All-Cause Readmissions***	17.23%	9.88%	7.35	11.92%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that HPSJ stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 SPD rates were significantly better than the reporting year 2018 SPD rates for the following measures:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in San Joaquin County.
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Stanislaus County.

- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the following measures:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in both reporting units.
  - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in San Joaquin County.
  - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* in Stanislaus County.
  - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* in both reporting units.
- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rate was significantly better than the reporting year 2019 non-SPD rate for the following measures:
    - Both *Annual Monitoring for Patients on Persistent Medications* measures in both reporting units.
    - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years* in Stanislaus County.
  - The reporting year 2019 SPD rates were significantly worse than the reporting year 2019 non-SPD rates for the *Plan All-Cause Readmissions* measure in both reporting units. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that HPSJ followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for HPSJ:

- Across all domains, 13 of 38 rates (34 percent) improved significantly from reporting year 2018 to reporting year 2019.
- As listed below, 12 of the 14 rates that were below the minimum performance levels in reporting year 2018 (86 percent) moved to above the minimum performance levels in reporting year 2019:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in both reporting units
  - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Stanislaus County

- *Breast Cancer Screening* in both reporting units
- *Childhood Immunization Status—Combination 3* in both reporting units
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Stanislaus County
- *Comprehensive Diabetes Care— HbA1c Testing* in Stanislaus County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Stanislaus County
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Stanislaus County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Stanislaus County

Opportunities for Improvement—Performance Measures

Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, HSAG identified the following opportunities for improvement for HPSJ:

- Identify the causes for the *Asthma Medication Ratio* measure rate declining significantly from reporting year 2018 to reporting year 2019 in both reporting units and develop strategies, as applicable, to address the causes for the significant decline, which resulted in the rate in San Joaquin County moving to below the minimum performance level in reporting year 2019.
- Determine whether current strategies need to be modified or expanded to improve the rate for the *Comprehensive Diabetes Care—HbA1c Testing* measure in San Joaquin County to above the minimum performance level.

In addition to the opportunities for improvement listed previously, HPSJ has opportunities for improvement related to the following four measures with rates below the minimum performance levels in reporting year 2019:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* in San Joaquin County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in San Joaquin County
- Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures in Stanislaus County

HSAG makes no formal recommendations for these four measures because DHCS will not require MCPs to report the measures to DHCS in reporting year 2020, and DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCP's quality improvement actions related to the measures. DHCS and HSAG expect that HPSJ will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCP will conduct improvement activities, as applicable, related to these four measures.

Except for the two *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures, NCQA made specification changes in reporting year 2019 for the measures included under this heading ("Opportunities for Improvement—Performance Measures"); therefore, HPSJ's reporting year 2019 performance for these measures may be due to NCQA's specification changes and may not be related to the MCP's performance.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, HPSJ conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required HPSJ to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, HPSJ identified cervical cancer screening among White women, ages 24 to 64, residing in Stanislaus County as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—HPSJ *Cervical Cancer Screening* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of cervical cancer screening compliance among White women, ages 24 to 64, residing in Stanislaus County	44.75%	49.20%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Cervical Cancer Screening* Disparity PIP. Upon initial review of the module, HSAG determined that HPSJ met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Including all required components of the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.

After receiving technical assistance from HSAG, HPSJ incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Cervical Cancer Screening* Disparity PIP, HSAG reviewed and provided feedback to HPSJ on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to HPSJ that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the intervention that HPSJ tested for its *Cervical Cancer Screening* Disparity PIP. The table also indicates the key drivers that the intervention addressed.

Table 4.2—HPSJ *Cervical Cancer Screening* Disparity PIP Intervention Testing

Intervention	Key Drivers Addressed
Provide appointment scheduling assistance and offer clinic days to provide incentives to beneficiaries who complete their cervical cancer screenings.	♦ Data integrity ♦ Access ♦ Communication ♦ Resources ♦ Education

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to HPSJ to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although HPSJ completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in HPSJ's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required HPSJ to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, HPSJ selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—HPSJ *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of *Childhood Immunization Status—Combination 3* compliance among beneficiaries residing in San Joaquin County who have Medical Center A[6] as their PCP.	5.11%	20.00%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 1 through 3 for the MCP's *Childhood Immunization Status—Combination 3* PIP. Upon initial review of the modules, HSAG determined that HPSJ met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Supporting the topic selection with the MCP's data.
- Identifying appropriate team members, to include both internal staff and external partners.
- Including all required components of the:
  - SMART Aim, developed based on literature review, data, and/or experience.
  - SMART Aim measure.
  - SMART Aim data collection methodology.
  - Run/control chart.
  - FMEA table.
- Aligning accurately the Global Aim, SMART Aim, key drivers, and potential interventions.
- Including a step-by-step flow of the overall process in the process map.
- Supporting the subprocesses selection for the FMEA table.
- Describing the priority-ranking process.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, HPSJ incorporated HSAG's feedback into modules 1 through 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for modules 1 through 3.

[6] Medical center name removed for confidentiality.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 3* PIP, HSAG reviewed and provided feedback to HPSJ on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to HPSJ that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the intervention that HPSJ tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the failure mode that the intervention addressed.

Table 4.4—HPSJ *Childhood Immunization Status—Combination 3* PIP Intervention Testing

Intervention	Failure Mode Addressed
Make outreach calls and send text messages to the parents of noncompliant beneficiaries.	Parents do not understand the importance of having their child immunized.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to HPSJ to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although HPSJ completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in HPSJ's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, HPSJ submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on HPSJ's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with HPSJ, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from HPSJ's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of HPSJ's self-reported actions.

Table 8.1—HPSJ's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP resolves the deficiencies that A&I identified in the Case Management and Coordination of Care category during the July 31, 2017, through August 9, 2017, Medical and State Supported Services Audits.	For Q1: On July 18, 2019, a letter from Janelle Gilmore, contract manager at DHCS, noted that the corrective actions taken by HPSJ satisfied the deficiencies in the Case Management and Coordination of Care category from the July 31, 2017, through August 9, 2017, Medical and State Supported Services Audits. The deficiency is closed.
2. Continue efforts to identify beneficiaries with retroactive eligibility to determine whether or not exclusion of those beneficiaries impacts the reported HEDIS rates.	HPSJ was able to improve the process for capturing enrollment data for the HEDIS January production run with a more accurate enrollment file. Enrollment data were incorporated after the FAME file upload to the MCP in January. Although we understand there might be members disenrolled after January, our HEDIS certified software vendor does not accommodate updates to the enrollment data after the production run.

2017–18 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
3. Assess whether or not the MCP's current improvement strategies need to be modified or expanded to improve the MCP's performance for the following measures with rates below the minimum performance levels in reporting year 2018: a. *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in both reporting units b. *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Stanislaus County c. *Childhood Immunization Status—Combination 3* in both reporting units d. *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in Stanislaus County e. *Comprehensive Diabetes Care—HbA1c Testing* in both reporting units f. *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in both reporting units g. *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Stanislaus County	Each measure listed was the subject of a PDSA conducted by HPSJ during the measurement period. Based on the PDSA solely, it was determined that the MCP would need to conduct systemwide improvement in order to successfully improve all measure rates to above the minimum performance levels. The PDSAs tested small interventions at the individual provider level with provider cooperation effecting measurable outcomes. The MCP decided to perform larger interventions aimed at members across both counties and several provider groups in order to have statistically significant outcomes. To impact each of the measures, several interventions aimed at providers, data, and members needed to be simultaneously initiated. The MCP addressed interventions across provider, member, and data in order to improve all measures' rates to above the minimum performance levels. HEDIS continued to be a corporate objective, and the MCP formed a HEDIS workgroup which contained members from every business unit within the MCP.

2017–18 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
4. For the following measures, assess the causes for the MCP's performance below the minimum performance levels in reporting year 2018 and identify strategies to improve performance: a. *Breast Cancer Screening* in both reporting units b. *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Stanislaus County	HPSJ determined several factors for its performance below the minimum performance levels for both measures. ***Breast Cancer Screening*** The MCP determined that members were not receiving their screening based on perceived issues such as the procedure being painful, the screening not being needed, and the members being provided miseducation regarding timing of the screenings. The MCP launched a call campaign to discuss with members their specific reasons for not receiving services, and then started working to remove barriers. Workgroups then began to plan interventions which included partnering with community organizations to provide education and working with providers to remove barriers. During reporting year 2018, the interventions were just beginning, and the MCP believes that its efforts will be reflected in measurement year 2019. ***Prenatal and Postpartum Care*** The MCP determined that several factors contributed to poor performance in these rates primarily related to the data being received, and providers' understanding of billing. Providers often used a global code. This meant the providers would enter one code during the initial visit, and billing for the second visit would not be captured. HPSJ worked with providers to ensure they will utilize the proper coding on subsequent visits. The MCP also worked to identify populations with gaps in care, and assisted them with transportation, appointment scheduling, and providing member incentives at the point of service. The MCP conducted additional member-focused campaigns and held provider lunch and learns to ensure a full understanding of the measure

2017–18 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	and the reasons for timely service. The interventions were implemented throughout reporting years 2018 and 2019. The MCP also worked with provider offices to ensure accurate encounter reporting and timely claims submission.
5. Incorporate lessons learned from the 2015–17 *Cervical Cancer Screening* PIP into the 2017–19 *Cervical Cancer Screening* Disparity PIP.	♦ We previously focused on our Hispanic population since they make up the majority of our membership. We found during the Disparity PIP that our Caucasian population, even though smaller in number, was less likely to get their screening done. We found that there is a disparity in Stanislaus County to that effect, and it is mirrored in our largest providers in Stanislaus. ■ Based on provider reports that there is a large Middle Eastern population in Stanislaus County and that U.S. Census records include people of Middle Eastern descent under the White/Caucasian category, we understand that this might impact the rates. ♦ From a cultural perspective, women's reproductive health education is still culturally taboo in several countries around the world. This is compounded by some belief groups and cultures having only female doctors tending to women, especially for reasons surrounding reproductive health and pregnancy. ■ This disparity has been communicated with our largest providers, and they have begun to work with us to address the issue. ♦ We previously left it up to the provider office to track those outreached and those seen for services. We found that providers

2017–18 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	are either unable or unwilling to keep records regarding only HPSJ members contacted and seen. This time, although we have worked with the same provider, we are taking a more active role regarding those who are being seen for services. This is being achieved by having a presence in the clinic on the special days set aside for these members in order to hand out incentives on the same day the members receive services.
6. Apply the lessons learned from both 2015–17 PIPs to facilitate improvement for future PIPs.	The lessons learned from our *Cervical Cancer Screening* PIP have been incorporated into all current and future PIPs. These include the following: ♦ We previously left it up to the provider office to track those outreached and those seen for services. We found that providers were either unable or unwilling to keep records regarding only HPSJ members contacted and seen. This time, although we have worked with the same provider, we are taking a more active role regarding those who are being seen for the services. This is being achieved by having a presence in the clinic on the special days set aside for these members in order to hand out incentives on the same day the members receive services. ♦ Incentivizing members at the point of care helps to reduce the no-show rate and close member gaps. Allowing focused clinics allows intervention testing without the barrier of member no-shows.

Assessment of MCP's Self-Reported Actions

HSAG reviewed HPSJ's self-reported actions in Table 8.1 and determined that HPSJ adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. HPSJ described in detail actions taken during the review period, lessons learned, and steps the MCP plans to take moving forward. The self-reported actions HPSJ described in Table 8.1 may have contributed to the improvement for 12 rates that moved from below the minimum performance levels in reporting year 2018 to above the minimum performance levels in reporting year 2019.

2018–19 Recommendations

Based on the overall assessment of HPSJ's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Identify the causes for the *Asthma Medication Ratio* measure rate declining significantly from reporting year 2018 to reporting year 2019 in both reporting units and develop strategies, as applicable, to address the causes for the significant decline, which resulted in the rate in San Joaquin County moving to below the minimum performance level in reporting year 2019.
- Determine whether current strategies need to be modified or expanded to improve the rate for the *Comprehensive Diabetes Care—HbA1c Testing* measure in San Joaquin County to above the minimum performance level.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix S:
Performance Evaluation Report
Health Plan of San Mateo
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Health Plan of San Mateo ("HPSM" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in HPSM's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

HPSM is a full-scope MCP delivering services to beneficiaries in the County Organized Health System model.

HPSM became operational to provide MCMC services in San Mateo County effective December 1987. As of June 2019, HPSM had 101,594 beneficiaries in San Mateo County.[1]

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for HPSM. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of HPSM. A&I conducted the audits from October 9, 2018, through October 19, 2018. During the audits, A&I examined HPSM's compliance with its DHCS contract and assessed the MCP's implementation of the CAP from the 2017 A&I Medical Audit. Note that HSAG provided a summary of the 2017 A&I Medical Audit in HPSM's 2017–18 MCP-specific evaluation report.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of HPSM
Audit Review Period: November 1, 2017, through September 30, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	Yes	CAP in process and under review.

Strengths—Compliance Reviews

A&I identified no findings in the Administrative and Organizational Capacity category during the October 2018 Medical and State Supported Services Audits of HPSM.

Opportunities for Improvement—Compliance Reviews

HPSM has the opportunity to work with DHCS to ensure that the MCP fully resolves all findings from the 2017 A&I Medical Audit and October 2018 A&I Medical and State Supported Services Audits.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for Health Plan of San Mateo* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that HPSM followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for HPSM's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
HPSM—San Mateo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	78.08%	82.99%	80.80%	79.26%	-1.54
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**92.20%**	93.74%	94.46%	96.03%	1.57

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.45%	85.91%	85.95%	88.03%	2.08
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	90.97%	89.52%	89.82%	92.33%	2.51
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.89%	86.17%	86.97%	89.78%	2.81
Immunizations for Adolescents—Combination 2	—	38.93%	55.47%	52.83%	-2.64
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	79.08%	77.22%	80.85%	81.94%	1.09

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	68.62%	65.00%	78.19%	80.21%	2.02
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.34%	76.61%	74.43%	76.01%	1.58

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
HPSM—San Mateo County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	5	40.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
HPSM—San Mateo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	65.77%	62.80%	63.05%	0.25
Cervical Cancer Screening	54.79%	55.26%	59.95%	70.10%	10.15
Prenatal and Postpartum Care—Postpartum Care	64.84%	67.11%	74.59%	82.55%	7.96
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.95%	82.63%	83.88%	85.67%	1.79

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings HPSM—San Mateo County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	3	33.33%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
HPSM—San Mateo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.92%	90.90%	90.46%	90.76%	0.30

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.69%	90.54%	91.35%	90.55%	-0.80
*Asthma Medication Ratio^*	—	54.89%	58.15%	58.03%	-0.12
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	61.12%	61.80%	68.46%	67.32%	-1.14
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	58.92%	64.48%	70.42%	65.61%	-4.81
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	48.90%	54.26%	52.81%	50.00%	-2.81
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	43.52%	36.01%	36.19%	39.51%	3.32
*Comprehensive Diabetes Care—HbA1c Testing^*	86.55%	85.40%	91.20%	87.32%	-3.88
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	87.29%	89.78%	92.18%	92.20%	0.02
Controlling High Blood Pressure	—	—	—	65.69%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
HPSM—San Mateo County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent

services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.

- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain Multi-Year Performance Measure Results HPSM—San Mateo County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	48.44	46.37	46.53	47.94	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	403.76	381.24	406.17	417.13	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	36.05%	48.67%	62.88%	61.26%	-1.62
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	0.80%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	61.65%	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	15.03%	Not Comparable
Use of Imaging Studies for Low Back Pain	84.38%	78.93%	81.64%	81.08%	-0.56

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures

- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
HPSM—San Mateo County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	2	100.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of HPSM's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
HPSM—San Mateo County

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	5	19	26.32%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	19	0.00%

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table
HPSM—San Mateo County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.12.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	62.09	60.02	61.70	62.55	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	814.59	826.61	867.25	921.72	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.36%	92.15%	92.37%	93.07%	0.70
Annual Monitoring for Patients on Persistent Medications—Diuretics	92.35%	92.66%	93.82%	93.52%	-0.30
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	78.42%	72.57%	72.68%	95.56%	22.88
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	73.24%	75.30%	76.03%	92.27%	16.24

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	71.23%	69.98%	70.65%	89.93%	19.28
*Plan All-Cause Readmissions***	—	—	—	21.98%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
HPSM—San Mateo County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	45.75	44.04	44.13	45.52	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	322.75	305.27	333.19	333.52	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.26%	88.87%	87.52%	87.08%	-0.44
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.58%	86.99%	87.52%	85.99%	-1.53
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	92.21%	93.81%	94.47%	96.02%	1.55
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.63%	86.19%	86.20%	87.92%	1.72
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.70%	90.01%	90.23%	92.33%	2.10

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.65%	86.79%	87.53%	89.77%	2.24
*Plan All-Cause Readmissions***	—	—	—	12.62%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations HPSM—San Mateo County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

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

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	62.55	45.52	Not Tested	47.94
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	921.72	333.52	Not Tested	417.13
Annual Monitoring for Patients on Persistent Medications— ACE Inhibitors or ARBs	93.07%	87.08%	5.99	90.76%
Annual Monitoring for Patients on Persistent Medications— Diuretics	93.52%	85.99%	7.53	90.55%
Children and Adolescents' Access to Primary Care Practitioners— 12–24 Months	NA	96.02%	Not Comparable	96.03%
Children and Adolescents' Access to Primary Care Practitioners— 25 Months–6 Years	95.56%	87.92%	7.64	88.03%
Children and Adolescents' Access to Primary Care Practitioners— 7–11 Years	92.27%	92.33%	-0.06	92.33%
Children and Adolescents' Access to Primary Care Practitioners— 12–19 Years	89.93%	89.77%	0.16	89.78%
*Plan All-Cause Readmissions***	21.98%	12.62%	9.36	15.03%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that HPSM stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 SPD rates were significantly better than the reporting year 2018 SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years* measures.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly better

than the reporting year 2018 non-SPD rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures.

- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
    - Both *Annual Monitoring for Patients on Persistent Medications* measures
    - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
  - The reporting year 2019 SPD rate was significantly worse than the reporting year 2019 non-SPD rate for the *Plan All-Cause Readmissions* measure. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that HPSM followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for HPSM:

- No rates were below the minimum performance levels.
- The rates for the following five of 19 measures (26 percent) were above the high performance levels:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*—The rate for this measure was above the high performance level for the third consecutive year.
  - *Immunizations for Adolescents—Combination 2*
  - *Prenatal and Postpartum Care—Postpartum Care*—The rate for this measure improved significantly from reporting year 2018 to reporting year 2019.
  - *Use of Imaging Studies for Low Back Pain*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total*

Opportunities for Improvement—Performance Measures

Based on HPSM's reporting year 2019 performance measure results, HSAG has no recommendations for the MCP in the area of performance measures.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to HPSM's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that HPSM report rates for three HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for reporting years 2016 through 2019. The reporting year is the year in which the MLTSSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between reporting year 2018 and reporting year 2019. Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of those changes.

Table 4.1—Multi-Year MLTSSP Performance Measure Results
HPSM—San Mateo County

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	76.52	73.62	76.09	79.09	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	630.77	627.79	658.29	687.62	Not Tested
Medication Reconciliation Post-Discharge	21.41%	30.41%	37.71%	41.12%	3.41

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure showed no statistically significant change from reporting year 2018 to reporting year 2019.

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, HPSM conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required HPSM to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, HPSM identified cervical cancer screening among English-speaking beneficiaries as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.1—HPSM *Cervical Cancer Screening* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of cervical cancer screening among beneficiaries with English language preference, ages 24 to 64, and assigned to Provider A.[6]	56.7%	67.4%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Cervical Cancer Screening* Disparity PIP. Upon initial review of the module, HSAG determined that HPSM met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Supporting the sub-processes selection for the FMEA table.
- Including all required components of the FMEA table.
- Describing the priority-ranking process.
- Listing the appropriate potential interventions based on the ranked failure modes.

[6] Provider name removed for confidentiality.

After receiving technical assistance from HSAG, HPSM incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Cervical Cancer Screening* Disparity PIP, HSAG reviewed and provided feedback to HPSM on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to HPSM that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.2 presents a description of the intervention that HPSM tested for its *Cervical Cancer Screening* Disparity PIP. The table also indicates the failure modes that the intervention addressed.

Table 5.2—HPSM *Cervical Cancer Screening* Disparity PIP Intervention Testing

Intervention	Failure Modes Addressed
Outreach to women who are due for a cervical cancer screening and have not been to Provider A for a primary care visit either 1) in the last 12 months or 2) since their assignment to Provider A membership panel.	♦ Women do not meet Provider A's criteria of having a prior primary care provider (PCP) visit in the past 12 months for targeted cervical cancer screening outreach. ♦ Women not scheduled for a primary care visit since being assigned to Provider A.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to HPSM to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although HPSM completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in HPSM's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required HPSM to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. However, based on HPSM demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic

related to an identified area in need of improvement. HPSM selected asthma medication ratio as its 2017–19 DHCS-priority PIP topic based on its MCP-specific data.

Table 5.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.3—HPSM *Asthma Medication Ratio* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of asthma medication ratio of 0.50 or greater for the rolling 12-month lookback period among beneficiaries ages 19 to 50 living with persistent asthma.	60.0%	71.0%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the MCP's *Asthma Medication Ratio* PIP. Upon initial review of the module, HSAG determined that HPSM met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Supporting the sub-processes selection for the FMEA table.
- Including all required components of the FMEA table.

After receiving technical assistance from HSAG, HPSM incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Asthma Medication Ratio* PIP, HSAG reviewed and provided feedback to HPSM on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to HPSM that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.4 presents a description of the intervention that HPSM tested for its *Asthma Medication Ratio* PIP. The table also indicates the key drivers and failure modes that the intervention addressed.

Table 5.4—HPSM *Asthma Medication Ratio* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Pilot asthma outreach to targeted beneficiaries ages 19 to 50 years who are not compliant with the *Asthma Medication Ratio* specification.	♦ Beneficiary knowledge. ♦ Beneficiary's perception. ♦ Continued use of controller medications. ♦ Beneficiaries forget to refill their controller medications. ♦ Beneficiaries are not motivated to refill their controller medications despite awareness of the importance of controller medication adherence. ♦ Beneficiaries are unaware or forget that controller medications are available for pick-up at a pharmacy. ♦ Beneficiaries do not pick up controller medications from a pharmacy despite awareness of prescriptions ordered.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to HPSM to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although HPSM completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in HPSM's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, HPSM submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on HPSM's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

7. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

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

8. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with HPSM, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

9. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 9.1 provides EQR recommendations from HPSM's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 9.1 to preserve the accuracy of HPSM's self-reported actions.

Table 9.1—HPSM's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Ensure that the MCP resolves all deficiencies from the November 27, 2017, through December 8, 2017, A&I Medical Audit.	HPSM has submitted to DHCS a formal CAP response with corrective actions described for all identified deficiencies. HPSM continues to communicate with DHCS regarding corrective actions that are in progress, had prospective compliance dates, or were identified as repeat issues in the subsequent 2018 A&I Medical Audit.
2. Assess the causes for the *Breast Cancer Screening* measure rate declining significantly from reporting year 2017 to reporting year 2018, and identify strategies to ensure that female beneficiaries ages 50 to 74 have a mammogram to screen for breast cancer within the appropriate time frame.	♦ Assessment of causes for the significant decline in the *Breast Cancer Screening* measure rate: ■ Women ages 50 to 74 due for breast cancer screening not connected to or receiving primary care services. ■ PCPs not assessing the need for breast cancer screening for the full panel of assigned members or outreaching to members due for breast cancer screenings. ■ Members referred for breast cancer screenings do not go to a

2017–18 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	radiology/imaging center to receive a mammogram. ♦ Strategies for ensuring Medi-Cal women ages 50 to 74 receive a routine mammogram: ■ Include the *Breast Cancer Screening* measure in HPSM's new Pay-for-Performance (P4P) program that provides annual bonus payments to PCPs for achieving the benchmark mammogram screening rate for assigned women on the panel. ■ Identify and list all procedure codes in the P4P program guidelines that are applicable to breast cancer screening. ■ Gather information on specific radiology/imaging centers in San Mateo County that confirm availability of mammography services to HPSM Medi-Cal members. Use this information in planning content for a new member page on HPSM's website, Cancer Screening for Women. Include referral requirements, the scheduling process, and phone and fax numbers. ■ Identify and reach out to small PCP practices with the lowest *Breast Cancer Screening* rates for members on the panel (below the 50th percentile). Address the need to identify assigned women who are not recently engaged in seeking primary care with a PCP and are due for a routine mammogram, for targeted outreach by a PCP and HPSM to schedule a mammogram.

2017–18 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
3. Continue monitoring adapted interventions and outcomes to facilitate improvement beyond the life of the 2015–17 *Postpartum Care* and *Cervical Cancer Screening* PIPs.	**Monitoring interventions for improvements in *Cervical Cancer Screening*** ♦ Include the *Cervical Cancer Screening* measure in the new P4P program that provides annual bonus payments to PCPs who reach the benchmark *Cervical Cancer Screening* rate for assigned women ages 21 to 64 on the panel. ♦ Identify and list all procedure codes in the P4P program guidelines that are applicable to cervical cancer screening. These include codes for cervical cytology screening and human papillomavirus (HPV) tests. ♦ Gather information on obstetrician/gynecologist practices in San Mateo County with female gynecologists who will accept HPSM Medi-Cal women for cervical cancer screening. On the HPSM website, highlight access to female gynecologists for women assigned to male PCPs who prefer female doctors for cervical cancer screening. ♦ Identify and reach out to small PCP practices with the lowest *Cervical Cancer Screening* rates for members on the panel (below the 50th percentile). Address the need to identify assigned women who are not recently engaged in seeking primary care with a PCP and who are due for cervical cancer screening, for targeted outreach by a PCP and HPSM to schedule a Pap test. **Prenatal/Postpartum Outreach Program Intervention** ♦ Continue targeted prenatal/postpartum outreach calls and piloting text message reminders about postpartum visits for program participants.

2017–18 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	♦ Continue community partnerships to link members to county home visiting/case management programs. ♦ Continue monitoring monthly dashboard data to measure effectiveness and reach of the program. ♦ Promote the program to HPSM's internal departments with direct member contact, network providers, and community partners. ♦ Continue to offer provider P4P bonus payments for postpartum visits. ♦ Expand the program to include components on maternal mental health and link member services for gestational diabetes. ♦ Work with the marketing department to rebrand the program and develop campaign materials, including posters, brochures, and website content.
4. Apply lessons learned from the 2015–17 *Cervical Cancer Screening* PIP to the MCP's 2017–19 *Cervical Cancer Screening* Disparity PIP.	2015–17 *Cervical Cancer Screening* PIP lessons applied to the *Cervical Cancer Screening* Disparity PIP intervention which was initiated January 1, 2019, at a provider partner. ♦ Adapted criteria for clinic outreach: broaden the definition of "inactive assigned patients" to include members without PCP visits within the past three years, based on clinic documentation. ♦ Encourage collaborative data collection (MCP and provider data) on assigned members due for cervical cancer screening to identify members disconnected from the provider partner. ♦ Request clinic documentation of outreach attempts with outcomes of invalid phone number and unable to leave message.

2017–18 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	♦ HPSM's quality improvement team makes plans to review the claims report of the last PCP visit for members confirmed by the MCP and provider data as inactive with the assigned PCP in the past three years.

Assessment of MCP's Self-Reported Actions

HSAG reviewed HPSM's self-reported actions in Table 9.1 and determined that HPSM adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. HPSM described in detail actions taken during the review period, lessons learned, and steps the MCP plans to take moving forward. HSAG identified the following notable actions taken by the MCP in response to the 2017–18 EQRO recommendations:

- Identified multiple causes for the *Breast Cancer Screening* measure rate declining significantly from reporting year 2017 to reporting year 2018 and implemented multiple strategies to ensure that female beneficiaries ages 50 to 74 have a mammogram to screen for breast cancer within the appropriate time frame.
- Continued monitoring adapted interventions and outcomes from the 2015–17 *Postpartum Care* and *Cervical Cancer Screening* PIPs and expanded successful strategies.
- Applied lessons learned from the 2015–17 *Cervical Cancer Screening* PIP to the MCP's 2017–19 *Cervical Cancer Screening* Disparity PIP intervention.

2018–19 Recommendations

Based on the overall assessment of HPSM's delivery of accessible and timely care through the activities described in previous sections of this report, HSAG recommends that HPSM work with DHCS to ensure that the MCP resolves all findings from the 2017 A&I Medical Audit and October 2018 A&I Medical and State Supported Services Audits.

In the next annual review, HSAG will evaluate continued successes of HPSM as well as the MCP's progress with this recommendation.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix T:
Performance Evaluation Report
Inland Empire Health Plan
July 1, 2018–June 30, 2019

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Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Inland Empire Health Plan ("IEHP" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in IEHP's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

IEHP is a full-scope MCP delivering services to beneficiaries as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in IEHP, the Local Initiative MCP; or in Molina Healthcare of California Partner Plan, Inc., the alternative commercial plan.

IEHP became operational in Riverside and San Bernardino counties to provide MCMC services effective September 1996. As of June 2019, IEHP had 608,549 beneficiaries in Riverside County, and 615,766 in San Bernardino County—for a total of 1,224,315 beneficiaries.[1] This represents 88 percent of the beneficiaries enrolled in Riverside County and 90 percent in San Bernardino County.

DHCS allows IEHP to combine data for Riverside and San Bernardino counties for reporting purposes. For this report, Riverside and San Bernardino counties are considered a single reporting unit.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for IEHP. The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of IEHP. A&I conducted the audits from September 24, 2018, through October 5, 2018. Note that DHCS sent IEHP its final response to the MCP's corrective action plan (CAP) on July 11, 2019, which is outside the review period for this report; however, HSAG includes the information because it reflects full resolution of all findings from the September 24, 2018, through October 5, 2018, audits.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of IEHP
Audit Review Period: October 1, 2017, through September 30, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	No	No findings.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	No	No findings.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in six of seven categories evaluated during the 2018 Medical and State Supported Services Audits. Additionally, IEHP's responses to the MCP's CAP for the findings A&I identified in the Member's Rights category during the audits resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

IEHP has no outstanding findings from the 2018 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for Inland Empire Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that IEHP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for IEHP's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

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

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
IEHP—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	70.83%	72.45%	73.97%	71.05%	-2.92
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**91.90%**	93.72%	93.78%	**93.48%**	-0.30

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**82.89%**	**83.28%**	**84.05%**	**84.29%**	0.24
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**83.43%**	**82.59%**	**83.26%**	**84.21%**	0.95
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**82.35%**	**81.72%**	**82.75%**	**83.06%**	0.31
Immunizations for Adolescents—Combination 2	—	23.61%	29.44%	39.42%	9.98
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	80.09%	80.09%	80.29%	81.75%	1.46

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	65.74%	68.06%	71.29%	80.29%	9.00
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.06%	73.15%	75.43%	74.94%	-0.49

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings IEHP—Riverside/San Bernardino Counties

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	5	20.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	5	40.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
IEHP—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	64.17%	67.07%	66.84%	-0.23
Cervical Cancer Screening	**54.12%**	58.59%	62.04%	64.96%	2.92
Prenatal and Postpartum Care—Postpartum Care	59.67%	64.19%	61.31%	66.42%	5.11
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.68%	83.49%	79.08%	80.29%	1.21

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings IEHP—Riverside/San Bernardino Counties

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
IEHP—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.11%	87.67%	88.78%	87.93%	-0.85
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.40%	86.94%	88.23%	87.76%	-0.47
*Asthma Medication Ratio^*	—	**49.22%**	55.41%	**55.59%**	0.18
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	59.16%	66.82%	65.21%	61.31%	-3.90
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	55.68%	60.56%	56.69%	60.58%	3.89

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	51.04%	52.90%	54.01%	57.42%	3.41
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	38.75%	37.12%	35.04%	32.36%	-2.68
*Comprehensive Diabetes Care—HbA1c Testing^*	86.77%	87.24%	84.91%	89.05%	4.14
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	92.58%	90.49%	91.97%	93.67%	1.70
Controlling High Blood Pressure	—	—	—	60.34%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
IEHP—Riverside/San Bernardino Counties

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	9	11.11%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	9	11.11%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	9	11.11%

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
IEHP—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

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

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	47.36	46.08	46.89	45.03	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	230.67	238.56	247.87	271.89	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	23.13%	27.30%	31.74%	31.97%	0.23
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	15.35%	Not Comparable
Use of Imaging Studies for Low Back Pain	73.96%	72.31%	71.83%	72.22%	0.39

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings IEHP—Riverside/San Bernardino Counties

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of IEHP's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
IEHP—Riverside/San Bernardino Counties

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

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	19	10.53%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	19	5.26%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	19	5.26%

Improvement Plan Requirements for 2019

Based on reporting year 2019 performance measure results, DHCS will require IEHP to submit an IP consisting of a minimum of two PDSA cycles for the *Asthma Medication Ratio* measure.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table IEHP—Riverside/San Bernardino Counties

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.12.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	81.09	78.53	76.15	71.89	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	472.31	508.82	539.19	600.20	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.24%	91.51%	92.17%	91.46%	-0.71
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.68%	91.58%	92.36%	91.88%	-0.48
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	97.81%	98.39%	94.37%	94.18%	-0.19
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.27%	86.92%	87.77%	86.90%	-0.87

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.53%	87.13%	86.68%	88.00%	1.32
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	81.53%	82.90%	83.22%	84.23%	1.01
*Plan All-Cause Readmissions***	—	—	—	22.20%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
IEHP—Riverside/San Bernardino Counties

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	44.57	43.67	44.61	42.86	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	210.73	218.45	225.13	245.35	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.47%	85.77%	87.06%	86.05%	-1.01
Annual Monitoring for Patients on Persistent Medications—Diuretics	84.52%	84.48%	86.04%	85.44%	-0.60
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	91.86%	93.68%	93.77%	93.48%	-0.29
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	82.81%	83.20%	83.97%	84.23%	0.26

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	83.30%	82.42%	83.14%	84.07%	0.93
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	82.39%	81.67%	82.73%	83.01%	0.28
*Plan All-Cause Readmissions***	—	—	—	12.54%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations IEHP—Riverside/San Bernardino Counties

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

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

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	71.89	42.86	Not Tested	45.03
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	600.20	245.35	Not Tested	271.89
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.46%	86.05%	5.41	87.93%
Annual Monitoring for Patients on Persistent Medications— Diuretics	91.88%	85.44%	6.44	87.76%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.18%	93.48%	0.70	93.48%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.90%	84.23%	2.67	84.29%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	88.00%	84.07%	3.93	84.21%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.23%	83.01%	1.22	83.06%
*Plan All-Cause Readmissions***	22.20%	12.54%	9.66	15.35%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that IEHP stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 SPD rate was significantly worse than the reporting year 2018 SPD rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure.

- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019:
  - The reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* measures.
  - The reporting year 2019 non-SPD rate was significantly worse than the reporting year 2018 non-SPD rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure.
- The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
  - Both *Annual Monitoring for Patients on Persistent Medications* measures
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*.
- The reporting year 2019 SPD rate was significantly worse than the reporting year 2019 non-SPD rate for the *Plan All-Cause Readmissions* measure. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that IEHP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for IEHP:

- The rates for the following two measures improved significantly from reporting year 2018 to reporting year 2019:
  - *Immunizations for Adolescents—Combination 2*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total*, resulting in the rate for this measure moving to above the high performance level in reporting year 2019.
- The rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure was above the high performance level.

Opportunities for Improvement—Performance Measures

Although the *Asthma Medication Ratio* measure rate did not decline from reporting year 2018 to reporting year 2019, the rate moved from above the minimum performance level in reporting year 2018 to below the minimum performance level in reporting year 2019. This is because the minimum performance level increased by 1.52 percentage points from reporting year 2018 to reporting year 2019.

Based on reporting year 2019 performance measure results, IEHP has the opportunity to identify the causes for the *Asthma Medication Ratio* measure rate being below the minimum performance level and to develop strategies, as applicable, to ensure that beneficiaries ages 5 to 64 who are identified as having persistent asthma have a ratio of controller medications to total asthma medications of 0.50 or greater.

While the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure declined significantly from reporting year 2018 to reporting year 2019, HSAG makes no formal recommendations to the MCP related to this measure due to the small range of variation between the high performance level and minimum performance level thresholds for the measure.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to IEHP's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that IEHP report rates for three HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for reporting years 2016 through 2019. The reporting year is the year in which the MLTSSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between reporting year 2018 and reporting year 2019. Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of those changes.

Table 4.1—Multi-Year MLTSSP Performance Measure Results
IEHP—Riverside/San Bernardino Counties

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

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

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

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	93.97	99.38	92.70	90.22	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	573.50	689.51	717.44	748.42	Not Tested
Medication Reconciliation Post-Discharge	15.44%	41.94%	31.63%	39.90%	8.27

Managed Long-Term Services and Supports Plan Performance Measure Findings

The *Medication Reconciliation Post-Discharge* measure rate improved significantly from reporting year 2018 to reporting year 2019.

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, IEHP conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required IEHP to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, IEHP identified immunizations among African-American children residing in the Riverside Region as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.1—IEHP *Childhood Immunization Status—Combination 10* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of the *Childhood Immunization Status—Combination 10* measure among beneficiaries who identify as Black residing in the Riverside Region	7.64%	15.98%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Childhood Immunization Status—Combination 10* Disparity PIP. Upon initial review of the module, HSAG determined that IEHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Including all required components of the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the potential reliability and sustainability of the interventions.

After receiving technical assistance from HSAG, IEHP incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 10* Disparity PIP, HSAG reviewed and provided feedback to IEHP on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to IEHP that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.2 presents a description of the intervention that IEHP tested for its *Childhood Immunization Status—Combination 10* Disparity PIP. The table also indicates the key drivers and failure modes that the intervention addressed.

Table 5.2—IEHP *Childhood Immunization Status—Combination 10* Disparity PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Conduct home visits to beneficiaries' caregivers to provide culturally appropriate education on immunizations and promote adherence.	♦ Beneficiary awareness and education. ♦ Beneficiaries' caregivers are not provided with culturally appropriate information about the importance of immunizations. ♦ Beneficiaries' caregivers do not review educational materials provided. ♦ Beneficiaries' caregivers are unaware of the immunization schedule. ♦ Beneficiaries' caregivers struggle to follow the immunization schedule. ♦ Beneficiaries' caregivers do not perceive immunizations as necessary to maintain beneficiaries' health. ♦ Beneficiaries' caregivers perceive immunizations as harmful to beneficiaries.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to IEHP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although IEHP completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in IEHP's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required IEHP to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. However, based on IEHP demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. IEHP selected asthma medication ratio as its 2017–19 DHCS-priority PIP topic based on its MCP-specific data.

Table 5.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.3—IEHP *Asthma Medication Ratio* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of *Asthma Medication Ratio* measure among beneficiaries ages 5 to 65 years with persistent asthma who are assigned to partnering providers.	23.47%	33.47%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the MCP's *Asthma Medication Ratio* PIP. Upon initial review of the module, HSAG determined that IEHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Including all required components of the FMEA table.
- Considering the potential reliability and sustainability of the interventions.

After receiving technical assistance from HSAG, IEHP incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Asthma Medication Ratio* PIP, HSAG reviewed and provided feedback to IEHP on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to IEHP that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.4 presents a description of the intervention that IEHP tested for its *Asthma Medication Ratio* PIP. The table also indicates the key drivers and failure modes that the intervention addressed.

Table 5.4—IEHP *Asthma Medication Ratio* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Partner with a vendor that will provide targeted provider education and support in managing the asthma population; and conduct beneficiary outreach to educate beneficiaries on asthma medication management.	♦ Provider awareness and education of clinical pathways and population management strategies for asthma care management. ♦ Beneficiary awareness and education of asthma self-management through an asthma action plan. ♦ Development of a key asthma management intervention in partnership with a vendor. ♦ Provider is unable to identify beneficiaries with persistent asthma who are in need of an Asthma Action Plan. ♦ Provider does not have sufficient time or resources to monitor or review asthma medications. ♦ Beneficiaries are unaware of or do not understand the Asthma Action Plan. ♦ Provider does not develop an Asthma Action Plan with beneficiaries during visits. ♦ Provider does not actively manage beneficiaries' asthma condition.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to IEHP to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although IEHP completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in IEHP's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, IEHP submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on IEHP's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

7. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[6] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

[6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

8. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with IEHP, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

9. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 9.1 provides EQR recommendations from IEHP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 9.1 to preserve the accuracy of IEHP's self-reported actions.

Table 9.1—IEHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Apply the lessons learned from the 2015–17 *Diabetes HbA1c Testing* and *Cervical Cancer Screening* PIPs to facilitate improvement for future PIPs.	During the July 1, 2018, through June 30, 2019, PIP cycle, IEHP worked closely with internal workgroups and external partners to establish interventions that incorporated lessons learned from the 2015–17 PIP cycle evaluation findings. IEHP was careful to minimize additional factors that could result in an increased rate. If additional factors were not able to be removed, establishing a process to identify and measure the impact of the external factors was explored (for example, a member incentive intervention including the population in the *Childhood Immunization Status—Combination 3* PIP). Assigning a designated IEHP analyst to review the PIP data monthly ensured appropriate actions/modifications that could be made early in the PIP cycle, if needed.

2017–18 External Quality Review Recommendations Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	During the planning and intervention development phases, IEHP reviewed all details and expectations related to the PIP with the vendor. During the "plan" phase, this included weekly touch points. During the "do" phase, there were monthly exchanges of data, identification of barriers, collaborations to remove barriers, and follow-up calls as needed.

Assessment of MCP's Self-Reported Actions

HSAG reviewed IEHP's self-reported actions in Table 9.1 and determined that IEHP adequately addressed HSAG's recommendation from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. IEHP described how the MCP applied lessons learned from the 2015–17 *Diabetes HbA1c Testing* and *Cervical Cancer Screening* PIPs to the new PIPs. The MCP described how it approached the planning and intervention development phases, and how assigning a designated analyst to review the PIP data monthly allowed for course corrections as soon as issues were identified.

2018–19 Recommendations

Based on the overall assessment of IEHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that the MCP identify the causes for the *Asthma Medication Ratio* measure rate being below the minimum performance level and develop strategies, as applicable, to ensure that beneficiaries ages 5 to 64 who are identified as having persistent asthma have a ratio of controller medications to total asthma medications of 0.50 or greater.

In the next annual review, HSAG will evaluate continued successes of IEHP as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix U:
Performance Evaluation Report
Kern Family Health Care
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Kern Family Health Care ("KFHC" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in KFHC's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

KFHC is a full-scope MCP delivering services to beneficiaries as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in KFHC, the Local Initiative MCP; or in Health Net Community Solutions, Inc., the alternative commercial plan.

KFHC became operational in Kern County to provide MCMC services effective July 1996. As of June 2019, KFHC had 257,136 beneficiaries in Kern County.[1] This represents 79 percent of the beneficiaries enrolled in Kern County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent review conducted for KFHC. HSAG's compliance review summary is based on the final audit report issued and corrective action plan (CAP) closeout letter dated on or before the end of the review period for this report (June 30, 2019). The description of the review may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical Audit of KFHC. A&I conducted the audit from August 14, 2018, through August 17, 2018.

Table 2.1—DHCS A&I Medical Audit of KFHC
Audit Review Period: August 1, 2017, through July 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	Yes	CAP imposed and findings in this category rectified.
Access and Availability of Care	No	No findings.
Member's Rights	No	No findings.
Quality Management	No	No findings.
Administrative and Organizational Capacity	Yes	CAP imposed and findings in this category rectified.

Strengths—Compliance Reviews

During the August 2018 Medical Audit of KFHC, A&I identified no findings in the Utilization Management, Access and Availability of Care, Member's Rights, and Quality Management categories. KFHC's CAP response regarding the findings in the Case Management and Coordination of Care and Administrative and Organizational Capacity categories resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

KFHC has no outstanding findings from the August 2018 A&I Medical Audit; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for Kern Family Health Care* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that KFHC followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for KFHC's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

[4] Quality Compass® is a registered trademark of NCQA.

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
KFHC—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	66.91%	64.96%	68.86%	65.45%	-3.41
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**92.64%**	**89.65%**	**89.69%**	**89.62%**	-0.07

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**82.43%**	**80.61%**	**81.44%**	**80.28%**	-1.16
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**82.70%**	**81.49%**	**80.88%**	**79.90%**	-0.98
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**81.16%**	**80.21%**	**78.84%**	**78.35%**	-0.49
Immunizations for Adolescents—Combination 2	—	21.65%	36.74%	40.63%	3.89
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	66.67%	67.40%	63.02%	70.56%	7.54
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	57.91%	61.56%	57.91%	65.21%	7.30

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.15%	69.83%	66.67%	**63.99%**	-2.68

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings KFHC—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	5	40.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	5	20.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	5	20.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
KFHC—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**50.48%**	55.98%	56.57%	0.59
Cervical Cancer Screening	**52.07%**	58.39%	58.39%	60.34%	1.95
Prenatal and Postpartum Care—Postpartum Care	56.45%	63.50%	66.67%	67.64%	0.97
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.08%	75.43%	82.48%	81.27%	-1.21

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
KFHC—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
KFHC—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.26%	88.40%	90.19%	89.71%	-0.48
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.72%	87.61%	89.79%	90.50%	0.71
*Asthma Medication Ratio^*	—	**48.38%**	**49.80%**	**21.49%**	-28.31
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	61.86%	63.87%	69.89%	65.58%	-4.31
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	49.82%	48.36%	58.94%	56.88%	-2.06

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	40.88%	51.09%	58.21%	55.43%	-2.78
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	47.99%	39.60%	30.66%	33.15%	2.49
*Comprehensive Diabetes Care—HbA1c Testing^*	84.31%	84.49%	89.60%	89.13%	-0.47
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	90.51%	88.87%	92.88%	92.93%	0.05
Controlling High Blood Pressure	—	—	—	54.26%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
KFHC—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	9	11.11%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	8	0.00%

Assessment of Improvement Plans—Care for Chronic Conditions

Based on reporting year 2018 performance measure results, DHCS required KFHC to submit an IP for the *Asthma Medication Ratio* measure. KFHC conducted two PDSA cycles to help improve the MCP's performance on this measure. For each PDSA cycle, KFHC tested whether conducting beneficiary educational outreach would improve controller medication compliance for beneficiaries with asthma. The MCP reported learning that conducting follow-up calls to beneficiaries to remind them that their medications are available for pick-up would reinforce the importance of obtaining and taking the medications as prescribed.

The rate for the *Asthma Medication Ratio* measure remained below the minimum performance level in reporting year 2019.

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
KFHC—Kern County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	48.07	47.03	45.01	40.66	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	256.00	286.04	328.16	323.38	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	**21.22%**	29.47%	27.63%	31.33%	3.70
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	13.67%	Not Comparable
Use of Imaging Studies for Low Back Pain	76.04%	**66.25%**	71.59%	73.33%	1.74

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures

- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings KFHC—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of KFHC's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
KFHC—Kern County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	19	15.79%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	1	19	5.26%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	18	5.56%

Improvement Plan Requirements for 2019

Based on reporting year 2019 performance measure results, KFHC will be required to submit IPs for the following measures:

- *Asthma Medication Ratio*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table
KFHC—Kern County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.12.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	49.74	86.90	91.75	30.69	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	248.86	547.55	625.73	291.86	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.03%	91.81%	92.68%	91.88%	-0.80
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.40%	91.03%	92.08%	92.20%	0.12
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	95.56%	89.36%	92.86%	93.48%	0.62
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	85.04%	83.85%	87.41%	86.28%	-1.13
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.93%	85.86%	84.19%	82.67%	-1.52

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	78.65%	81.61%	80.09%	81.19%	1.10
*Plan All-Cause Readmissions***	—	—	—	18.31%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
KFHC—Kern County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	47.96	44.70	42.26	41.31	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	256.47	270.75	310.70	325.43	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.57%	87.35%	89.37%	89.00%	-0.37
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.39%	86.24%	88.87%	89.80%	0.93
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	92.62%	89.65%	89.67%	89.59%	-0.08
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	82.38%	80.55%	81.32%	80.14%	-1.18
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	82.54%	81.35%	80.78%	79.80%	-0.98

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	81.29%	80.15%	78.79%	78.23%	-0.56
*Plan All-Cause Readmissions***	—	—	—	12.47%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations KFHC—Kern County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	30.69	41.31	Not Tested	40.66

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	291.86	325.43	Not Tested	323.38
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.88%	89.00%	2.88	89.71%
Annual Monitoring for Patients on Persistent Medications—Diuretics	92.20%	89.80%	2.40	90.50%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	93.48%	89.59%	3.89	89.62%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.28%	80.14%	6.14	80.28%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	82.67%	79.80%	2.87	79.90%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	81.19%	78.23%	2.96	78.35%
*Plan All-Cause Readmissions***	18.31%	12.47%	5.84	13.67%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that KFHC stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, KFHC had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly worse than the reporting year 2018 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *7–11 Years* measures.
- The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
  - Both *Annual Monitoring for Patients on Persistent Medications* measures

  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*.
- The reporting year 2019 SPD rate was significantly worse than the reporting year 2019 non-SPD rate for the *Plan All-Cause Readmissions* measure. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that KFHC followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified that across all domains, the rates for the following measures improved significantly from reporting year 2018 to reporting year 2019:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures

Opportunities for Improvement—Performance Measures

While KFHC's self-reported actions describe the MCP's efforts to improve performance on the *Asthma Medication Ratio* measure (see Table 8.1), the rate for this measure declined significantly from reporting year 2018 to reporting year 2019 and remained below the minimum performance level in reporting year 2019. KFHC has the opportunity to assess whether the MCP should make changes to its current improvement strategies to ensure that beneficiaries ages 5 to 64 who are identified as having persistent asthma have a ratio of controller medications to total asthma medications of 0.50 or greater.

Additionally, to improve the MCP's performance to above the minimum performance level for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, KFHC has the opportunity to determine the factors preventing beneficiaries ages 3 to 6 from being seen for one or more well-child visit(s) with a primary care provider (PCP) during the measurement year, and to identify strategies to address these factors.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, KFHC conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's module submissions for both these PIPs as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required KFHC to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, KFHC identified immunizations among African-American children as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—KFHC *Childhood Immunization Status—Combination 3* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of *Childhood Immunization Status—Combination 3* measure among African-American children receiving primary care services at Clinic A[6]	19%	40%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Childhood Immunization Status—Combination 3* Disparity PIP. Upon initial review of the module, HSAG determined that KFHC met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Supporting the sub-processes selection for the FMEA table.
- Including all required components of the FMEA table.
- Describing the priority-ranking process.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the potential interventions' reliability and sustainability.

[6] Clinic name removed for confidentiality.

After receiving technical assistance from HSAG, KFHC incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 3* Disparity PIP, HSAG reviewed and provided feedback to KFHC on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to KFHC that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the interventions that KFHC tested for its *Childhood Immunization Status—Combination 3* Disparity PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

Table 4.2—KFHC *Childhood Immunization Status—Combination 3* Disparity PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Add growth charts to the vaccine education at postpartum visits to assist in getting parents' buy-in to getting the children vaccinated.	♦ Education to make an informed decision and parents' buy-in. ♦ Parents are not provided with information about the importance of immunizations. ♦ Hearsay of potential side effects.
Provide Clinic A with a monthly list of beneficiaries who are noncompliant with the immunization schedule for the provider to contact the parents and schedule vaccination appointments.	♦ Lack of transportation. ♦ Access/wait time. ♦ Parents are not provided information on walk-in/Saturday clinics. ♦ Parent are not provided information about transportation assistance and the immunization schedule.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to KFHC and conducted technical assistance calls with the MCP staff members to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although KFHC completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in KFHC's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required KFHC to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. However, based on KFHC demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. KFHC selected use of imaging studies for lower back pain as its 2017–19 DHCS-priority PIP topic based on its MCP-specific data.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—KFHC *Use of Imaging Studies for Lower Back Pain* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of beneficiaries diagnosed with uncomplicated lower back pain, ages 18 to 50, and assigned to Provider B[7] who did not have an imaging study.	85.29%	95.29%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the MCP's *Use of Imaging Studies for Lower Back Pain* PIP. Upon initial review of the module, HSAG determined that KFHC met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Supporting the sub-processes selection for the FMEA table.
- Including all required components of the FMEA table.

After receiving technical assistance from HSAG, KFHC incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Use of Imaging Studies for Lower Back Pain* PIP, HSAG reviewed and provided feedback to KFHC on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to KFHC that the MCP

[7] Provider name removed for confidentiality.

should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the interventions that KFHC tested for its *Use of Imaging Studies for Lower Back Pain* PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

Table 4.4—KFHC *Use of Imaging Studies for Lower Back Pain* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Schedule a two-week follow-up appointment prior to the beneficiary leaving the clinic on the initial visit.	♦ Beneficiaries' inability to know what to do and where to go. ♦ Intensity of pain and poor control.
Implement provider compliance awareness and standardized education to promote use of standardized treatment protocol.	♦ No standardized protocol for treatment plan. ♦ Conservative treatment varies from provider to provider.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to KFHC and conducted technical assistance calls with MCP staff members to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although KFHC completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in KFHC's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, KFHC submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on KFHC's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[8] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

[8] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with KFHC, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from KFHC's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of KFHC's self-reported actions.

Table 8.1—KFHC's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to KFHC	Self-Reported Actions Taken by KFHC during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Increase efforts of encouraging providers to exchange data electronically via beneficiary portals and electronic medical records.	KFHC makes a plethora of electronic data available to providers via the KFHC provider portal. These data include gaps in care, patient rosters, eligibility information, prior authorization submission and lookup, claims lookup, pay-for-performance (P4P) data, practice management data, HEDIS data, and more. KFHC encourages and works with all providers to better communicate and transmit data between the two entities whenever possible. KFHC recently signed a new agreement with a laboratory provider to capture data, namely lab results/values to improve quality metrics as well as to potentially populate member and provider portals. KFHC also has established a 270/271 eligibility transaction with several provider groups.

2017–18 External Quality Review Recommendations Directed to KFHC	Self-Reported Actions Taken by KFHC during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
2. Assess the causes for the *Asthma Medication Ratio* measure rate being below the MPL in RY 2018, and identify strategies to ensure that beneficiaries ages 5 to 64 who are identified as having persistent asthma have a ratio of controller medications to total asthma medications of 0.50 or greater.	KFHC will continue focusing on improving performance on the *Asthma Medication Ratio* measure by having *Asthma Medication Ratio* compliance as one of the Quality Improvement Department PIPs until improvement is achieved. Multiple departments within KFHC are continuing efforts to identify, educate, and follow up with members with persistent asthma. ♦ Pharmacy is engaging the network pharmacist to call physicians of members who are not meeting the *Asthma Medication Ratio* measure ratio. They will ask for a prescription and let the provider know the controller medication has not been filled, yet the members have rescue medications. ♦ KFHC's Health Education Department is partnering with Central California Asthma Collaborative (CCAC) on the Asthma Impact Model (AIM). This includes KFHC doing a pilot with CCAC for in-home visits to address not only environmental conditions related to asthma, but also evaluation and education about use of controller versus rescue medications. The health education team is also using incentives for members to attend asthma education classes. ♦ During provider medical record reviews, KFHC's quality improvement registered nurses (RNs) review the record to identify if an asthma controller is on the member's medication list and when it is not in the record, the information is made available to the physician to consider evaluating the member for controller medications. The

2017–18 External Quality Review Recommendations Directed to KFHC	Self-Reported Actions Taken by KFHC during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	RNs also promote the asthma health education classes. ♦ KFHC's Provider Relations Department now has the *Asthma Medication Ratio* measure as a P4P measure to encourage providers to promote use of controller medications by their asthma patients at or above a ratio of 0.50 compared to rescue medication. ♦ KFHC's provider portal has a page that outlines gaps in care, and one of the elements is members who have had rescue medication but no controller medication. ♦ KFHC's Disease Management Department continues follow-up efforts and addresses any challenges members might have in taking asthma medications.
3. Monitor the adopted and adapted interventions to achieve optimal outcomes beyond the life of the 2015–17 *Immunizations of Two-Year-Olds* and *Medication Management for People With Asthma* PIPs. The MCP should incorporate lessons learned from the 2015–17 PIPs to facilitate improvement of the adopted and adapted interventions.	The lessons learned from the 2015–17 PIPs resulted in the quality improvement RNs doing the following: ♦ Continuing to teach the usage of coding modifier-25 at site reviews as well as emphasizing the importance of proper coding to capture the work done by the provider. ♦ Strongly recommending the usage of California Immunization Registry 2 at the site reviews and notifying the provider of the California Immunization Registry 2 assessment on the new 2019 California Department of Public Health guidelines. ♦ Promoting health education asthma classes. ♦ Making sure an asthma controller is on the member's medication list if the member is diagnosed with asthma. Additionally, the Health Education Department has partnered with CCAC on AIM. This

2017–18 External Quality Review Recommendations Directed to KFHC	Self-Reported Actions Taken by KFHC during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	includes a pilot with CCAC for in-home visits to address not only environmental conditions related to asthma, but also evaluation and education about use of a controller versus rescue medications.
4. Apply lessons learned from the 2015–17 *Immunizations of Two-Year-Olds* PIP to the MCP's 2017–19 *Childhood Immunization Status—Combination 3* Disparity PIP.	From lessons learned from the 2015–17 *Childhood Immunization Status—Combination 3* PIP: ♦ At the initial 2017–19 *Childhood Immunization Status—Combination 3* PIP meeting at the clinic partner, roles and responsibilities were assigned and contact information shared. ♦ Monthly PIP status emails were sent out to the entire PIP team. ♦ The clinic partner assigned the directors of specific departments to represent the clinic partner on the PIP team. The challenge came with new clinic partner administration; three out of the five directors left the organization, and there was no accountability for previously assigned responsibilities. ♦ KFHC's Quality Improvement Department appreciated the increased technical assistance throughout 2018–19 as KFHC also experienced changes in quality improvement personnel. The DHCS teleconferences and HSAG's webinars helped KFHC to know what to focus on to complete the PIP.

Assessment of MCP's Self-Reported Actions

HSAG reviewed KFHC's self-reported actions in Table 8.1 and determined that KFHC adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. KFHC described actions taken during the review period, lessons learned, and steps the MCP plans to take moving forward. The MCP provided detailed descriptions of efforts to improve care for beneficiaries with persistent asthma,

including that the MCP is engaging in follow-up efforts to address challenges beneficiaries may have with taking their asthma medications. Additionally, KFHC provided information about how the MCP is applying lessons learned from the 2015–17 PIPs and how the MCP is building on successful efforts.

2018–19 Recommendations

Based on the overall assessment of KFHC's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Assess whether the MCP should make changes to its current improvement strategies related to the *Asthma Medication Ratio* measure to ensure that beneficiaries ages 5 to 64 who are identified as having persistent asthma have a ratio of controller medications to total asthma medications of 0.50 or greater.
- To improve the MCP's performance to above the minimum performance level for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, determine the factors preventing beneficiaries ages 3 to 6 from being seen for one or more well-child visit(s) with a PCP during the measurement year, and identify strategies to address the factors.

In the next annual review, HSAG will evaluate continued successes of KFHC as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix V:
Performance Evaluation Report
Kaiser NorCal (KP Cal, LLC, in Amador, El Dorado, Placer, and Sacramento Counties)
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, KP Cal, LLC, in Amador, El Dorado, Placer, and Sacramento counties (commonly known as "Kaiser Permanente North" and referred to in this report as "Kaiser NorCal" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in Kaiser NorCal's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Kaiser NorCal is a full-scope MCP delivering services to beneficiaries under two health care models. In Sacramento County, Kaiser NorCal serves beneficiaries under a Geographic Managed Care (GMC) model. The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

In addition to Kaiser NorCal, Sacramento County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Anthem Blue Cross Partnership Plan
- Health Net Community Solutions, Inc.
- Molina Healthcare of California Partner Plan, Inc.

In Amador, El Dorado, and Placer counties, Kaiser NorCal delivers services to its beneficiaries under the Regional model. In all three counties, beneficiaries may enroll in Kaiser NorCal or in Anthem Blue Cross Partnership Plan or California Health & Wellness Plan, the other commercial plans.

Kaiser NorCal became operational in Sacramento County to provide MCMC services effective April 1994. As part of MCMC's expansion under Section 1115 of the Social Security Act, Kaiser NorCal contracted with DHCS to provide MCMC services in Amador, El Dorado, and Placer counties beginning November 1, 2013. As of June 2019, Kaiser NorCal had 87,256 beneficiaries in Sacramento County, 105 in Amador County, 2,110 in El Dorado County, and 7,792 in Placer County.[1] This represents 20 percent of the beneficiaries enrolled in Sacramento County, 2 percent in Amador County, 7 percent in El Dorado County, and 17 percent in Placer County.

DHCS allows Kaiser NorCal to combine the data from Sacramento, Amador, El Dorado, and Placer counties for reporting purposes. For this report, these four counties are considered a single reporting unit (KP North).

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Kaiser NorCal. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Kaiser NorCal. A&I conducted the audits from October 1, 2018, through October 12, 2018. The scope of the audits included review of the Seniors and Persons with Disabilities (SPD) population in the areas of Utilization Management, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity. Additionally, A&I determined to what extent Kaiser NorCal had implemented the MCP's CAP from the October 9, 2017, through October 13, 2017, Medical Audit.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Kaiser NorCal Audit Review Period: September 1, 2017, through August 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in the Administrative and Organizational Capacity and State Supported Services categories during the October 2018 Medical and State Supported Services Audits of Kaiser NorCal.

Opportunities for Improvement—Compliance Reviews

Kaiser NorCal has the opportunity to work with DHCS to ensure that the MCP resolves all findings from the October 2018 Medical and State Supported Services Audits. The findings cut across the areas of quality and timeliness of, and access to, health care. Additionally, Kaiser NorCal has the opportunity to continue to work with DHCS to ensure that the MCP has fully addressed all findings from the October 2017 Medical Audit.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for Kaiser NorCal* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that Kaiser NorCal followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for Kaiser NorCal's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

[4] Quality Compass® is a registered trademark of NCQA.

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Kaiser NorCal—KP North

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	76.85%	79.35%	80.61%	80.16%	-0.45
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	98.66%	98.49%	99.05%	98.11%	-0.94

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	90.60%	90.00%	86.79%	85.56%	-1.23
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.71%	90.75%	88.87%	88.97%	0.10
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	93.15%	92.99%	90.24%	89.82%	-0.42
Immunizations for Adolescents—Combination 2	—	33.90%	55.17%	63.29%	8.12
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	91.64%	92.52%	91.48%	91.69%	0.21

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	91.54%	92.63%	91.54%	91.72%	0.18
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.02%	81.65%	80.77%	78.37%	-2.40

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Kaiser NorCal—KP North

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	4	5	80.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	4	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Kaiser NorCal—KP North

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	80.13%	81.41%	81.79%	0.38
Cervical Cancer Screening	84.93%	86.30%	86.01%	85.81%	-0.20
Prenatal and Postpartum Care—Postpartum Care	75.67%	73.28%	73.73%	74.67%	0.94
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.10%	92.89%	92.63%	92.35%	-0.28

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Kaiser NorCal—KP North

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	3	3	100.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Kaiser NorCal—KP North

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	92.74%	92.73%	93.54%	92.69%	-0.85
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.98%	91.40%	92.05%	92.22%	0.17
*Asthma Medication Ratio^*	—	84.84%	87.46%	87.98%	0.52
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	79.14%	77.64%	76.20%	75.43%	-0.77
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	68.11%	73.08%	75.11%	76.51%	1.40

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	61.39%	62.98%	62.60%	61.65%	-0.95
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	27.15%	24.54%	24.18%	24.09%	-0.09
*Comprehensive Diabetes Care—HbA1c Testing^*	93.18%	94.71%	94.83%	93.92%	-0.91
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	89.85%	88.84%	92.05%	91.09%	-0.96
Controlling High Blood Pressure	—	—	—	73.31%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Kaiser NorCal—KP North

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	5	9	55.56%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	4	8	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Kaiser NorCal—KP North

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	47.19	44.67	44.28	43.78	Not Tested

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	426.09	434.33	392.75	380.87	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	37.81%	33.33%	45.86%	48.88%	3.02
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	22.49%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	53.39%	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	12.21%	Not Comparable
Use of Imaging Studies for Low Back Pain	85.82%	82.35%	79.51%	83.53%	4.02

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Kaiser NorCal—KP North

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	2	100.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of Kaiser NorCal's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Kaiser NorCal—KP North

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	14	19	73.68%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Rates Above High Performance Levels for the Last Three or More Consecutive Years	8	16	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	19	0.00%

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the SPD population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table
Kaiser NorCal—KP North

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.12.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	78.94	74.15	71.60	68.55	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	848.88	885.37	767.24	728.29	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	95.70%	95.41%	96.01%	95.71%	-0.30
Annual Monitoring for Patients on Persistent Medications—Diuretics	94.12%	94.79%	95.63%	95.41%	-0.22
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	100.00%	100.00%	100.00%	100.00%	0.00
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	100.00%	100.00%	100.00%	100.00%	0.00

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	100.00%	100.00%	100.00%	100.00%	0.00
*Plan All-Cause Readmissions***	—	—	—	17.57%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
Kaiser NorCal—KP North

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	43.34	41.20	40.87	40.43	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	374.84	381.15	346.00	333.90	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.21%	90.46%	91.11%	89.43%	-1.68
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.44%	88.80%	88.67%	88.90%	0.23
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	98.65%	98.48%	99.04%	98.10%	-0.94
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	90.36%	89.73%	86.42%	85.20%	-1.22
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.40%	90.37%	88.45%	88.51%	0.06

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	92.83%	92.68%	89.84%	89.40%	-0.44
*Plan All-Cause Readmissions***	—	—	—	9.59%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Kaiser NorCal—KP North

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	68.55	40.43	Not Tested	43.78
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	728.29	333.90	Not Tested	380.87
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	95.71%	89.43%	6.28	92.69%
Annual Monitoring for Patients on Persistent Medications—Diuretics	95.41%	88.90%	6.51	92.22%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	98.10%	Not Comparable	98.11%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	100.00%	85.20%	14.80	85.56%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	100.00%	88.51%	11.49	88.97%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	100.00%	89.40%	10.60	89.82%
*Plan All-Cause Readmissions***	17.57%	9.59%	7.98	12.21%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that Kaiser NorCal stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, Kaiser NorCal had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly worse than the reporting year 2018 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* and *25 Months–6 Years* measures.

- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
    - Both *Annual Monitoring for Patients on Persistent Medications* measures
    - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years,* and *12–19 Years*
  - The reporting year 2019 SPD rate was significantly worse than the reporting year 2019 non-SPD rate for the *Plan All-Cause Readmissions* measure. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that Kaiser NorCal followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for Kaiser NorCal:

- Across all measures and domains, Kaiser NorCal performed above the high performance levels for 14 of 19 measures (74 percent), and the MCP had no measures with rates below the minimum performance levels.
  - Of the 16 measures for which the MCP reported rates for the last three or more consecutive years, eight measures (50 percent) were above the high performance levels for the last three or more consecutive years.
  - The MCP performed above the high performance levels for all measures within the Preventive Screening and Women's Health domain.

Opportunities for Improvement—Performance Measures

Based on reporting year 2019 performance measure results, Kaiser NorCal has the opportunity to identify the causes for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate declining significantly from reporting year 2018 to reporting year 2019 and to develop strategies to address the identified causes.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, Kaiser NorCal conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required Kaiser NorCal to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, Kaiser NorCal identified contraception use among adolescents in South Sacramento as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—Kaiser NorCal *Contraception* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of most to moderately effective forms of contraception use among beneficiaries ages 12 to 18 who have had a chlamydia test and who have a pediatrician in the South Sacramento service area.	68.35%	73.40%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Contraception* Disparity PIP. Upon initial review of the module, HSAG determined that Kaiser NorCal met some required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of the FMEA table.

After receiving technical assistance from HSAG, Kaiser NorCal incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Contraception* Disparity PIP, HSAG reviewed and provided feedback to Kaiser NorCal on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Kaiser NorCal that the MCP

should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the interventions that Kaiser NorCal tested for its *Contraception* Disparity PIP. The table also indicates the failure mode that each intervention addressed.

Table 4.2—Kaiser NorCal *Contraception* Disparity PIP Intervention Testing

Intervention	Failure Modes Addressed
Develop clear and consistent birth control counseling workflow and training for nurses.	The MCP did not identify which failure mode the intervention addressed.
Provide contraception counseling during adolescent routine well-visit appointment outreach calls.	Adolescent due for well-child visit.
Establish a process for doctors to make referrals to nurses to follow up on sexually active teens not using birth control to provide birth control counseling over the phone.	Follow-up call to sexually active teens who are seen in the clinic but do not select contraception.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Kaiser NorCal and conducted technical assistance calls with the MCP staff members to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although Kaiser NorCal completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Kaiser NorCal's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required Kaiser NorCal to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. However, based on Kaiser NorCal demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. Kaiser NorCal selected initial health assessments as its 2017–19 DHCS-priority PIP topic based on its MCP-specific data.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—Kaiser NorCal *Initial Health Assessment* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of initial health assessment (physical exam and health questionnaire) completion among beneficiaries assigned to Provider A[6]	25.7%	27.5%

Intervention Testing

Prior to the intervention testing phase of the MCP's *Initial Health Assessment* PIP, HSAG reviewed and provided feedback to Kaiser NorCal on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Kaiser NorCal that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the interventions that Kaiser NorCal tested for its *Initial Health Assessment* PIP. The table also indicates the failure mode that each intervention addressed.

Table 4.4—Kaiser NorCal *Initial Health Assessment* PIP Intervention Testing

Intervention	Failure Modes Addressed
Provide training to receptionists to improve knowledge on how to verify Medi-Cal coverage in HealthConnect.	Lack of knowledge about how to check and verify Medi-Cal coverage in HealthConnect.
Provide training to providers and medical assistants on the Medi-Cal program.	Lack of knowledge and education among providers and medical assistants about Medi-Cal program.
Provide training to physicians and medical assistants on the initial health assessment coding requirements.	Lack of consistent coding by providers and medical assistants for clinic visits.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Kaiser NorCal to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

[6] Provider name removed for confidentiality.

Although Kaiser NorCal completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Kaiser NorCal's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, Kaiser NorCal submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on Kaiser NorCal's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

[7] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with Kaiser NorCal, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from Kaiser NorCal's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of Kaiser NorCal's self-reported actions.

Table 8.1—Kaiser NorCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP resolves all deficiencies from the October 2017 A&I Medical Audit.	Kaiser NorCal continues to work with DHCS' Managed Care Quality and Monitoring Division (MCQMD) to address the deficiencies identified from the October 2017 A&I Medical Audit. CAPs were submitted on April 27, 2018, and updates have been provided to MCQMD throughout the year as requested; the last update was submitted on March 25, 2019. The 2017 audit remains open as the MCP continues to make enhancements to increase compliance with Medi-Cal provider training requirements. The MCP has made significant improvement in this area and anticipates closure of the 2017 audit soon.
2. Continue monitoring adapted and adopted interventions and outcomes to facilitate improvement beyond the life of the 2015–17 *Postpartum Care* and *Initial Health Assessment* PIPs.	♦ The Long-Acting Reversible Contraception (LARC) video we developed is now loaded on the Kaiser Permanente website—My Doctor Online—doctor homepages and has been shared with the Kaiser SoCal colleagues to use for patient education. ♦ Member engagement specialists ask during every new onboarding call whether the member is interested in preventing pregnancy in the next year. If so, and the

2017–18 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	patient is not using birth control, an appointment is booked with a gynecologist. ♦ The Health Care Coordinator (HCC) patient list includes high risk pregnancy and, at every transition, the HCC contacts the pregnant member. ♦ The texting campaign was extended to a 284-member intervention and control group to further test if texting is effective. Testing occurred March through December 2018. Outcomes were not replicated, and texting had no impact on the postpartum visit show rate.
3. Apply lessons learned from the 2015–17 *Initial Health Assessment* PIP to the MCP's 2017–19 *Initial Health Assessment* PIP.	♦ We continued our work on the initial health assessment (IHA) and expanded the scope to include the Sacramento service area for the 2017–19 PIP. ♦ Provider education and training must be ongoing and not provided on a one-time basis. Physicians and medical assistants in the Sacramento service area were trained on the IHA requirements and proper visit coding. Kaiser NorCal staff in the MCP's GMC Sacramento area have held multiple in-person follow-up trainings and continue to check in via email. ♦ Quality Assurance Process: The GMC staff continue to work in partnership with the medical group providers to assure that members' needs are documented and addressed in a timely manner. The member engagement specialists who are completing the IHA over the telephone were trained on using a new smart phrase, to have a standard documentation process for high-priority responses and resources provided during the onboarding call, and to allow providers to more easily review the actions taken and sign off on the encounter.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Kaiser NorCal's self-reported actions in Table 8.1 and determined that Kaiser NorCal adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. Kaiser NorCal described in detail actions taken during the review period and steps the MCP plans to take moving forward. Kaiser NorCal confirmed that the MCP is working with DHCS to ensure that the MCP resolves all deficiencies from the October 2017 A&I Medical Audit and noted that it anticipates DHCS will be closing the CAP soon. Kaiser NorCal also provided details about how the MCP continues to build on the interventions it tested as part of the MCP's 2015–17 *Postpartum Care* and *Initial Health Assessment* PIPs and how the MCP is applying lessons learned from the 2015–17 *Initial Health Assessment* PIP to the MCP's 2017–19 *Initial Health Assessment* PIP.

2018–19 Recommendations

Based on the overall assessment of Kaiser NorCal's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to ensure that the MCP resolves all findings from the October 2018 Medical and State Supported Services Audits.
- Continue to work with DHCS to ensure that the MCP has fully addressed all findings from the October 2017 Medical Audit.
- Identify the causes for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate declining significantly from reporting year 2018 to reporting year 2019 and develop strategies to address the identified causes.

In the next annual review, HSAG will evaluate continued successes of Kaiser NorCal as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix W:
Performance Evaluation Report
Kaiser SoCal (KP Cal, LLC, in San Diego County)
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, KP Cal, LLC, in San Diego County (commonly known as "Kaiser Permanente South" and referred to in this report as "Kaiser SoCal" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in Kaiser SoCal's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Kaiser SoCal is a full-scope MCP delivering services to beneficiaries under a Geographic Managed Care (GMC) model. The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

In addition to Kaiser SoCal, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Shield of California Promise Health Plan (known as Care1st Partner Plan prior to January 1, 2019)
- Community Health Group Partnership Plan
- Health Net Community Solutions, Inc.
- Molina Healthcare of California Partner Plan, Inc.
- UnitedHealthcare Community Plan

Kaiser SoCal became operational in San Diego County to provide MCMC services effective January 1998. As of June 2019, Kaiser SoCal had 49,530 beneficiaries.[1] This represents 7 percent of the beneficiaries enrolled in San Diego County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Kaiser SoCal. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Kaiser SoCal. A&I conducted the audits from October 1, 2018, through October 12, 2018. The scope of the audits included review of the Seniors and Persons with Disabilities (SPD) population in the areas of Utilization Management, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity. Additionally, A&I determined to what extent Kaiser SoCal had implemented the MCP's CAP from the October 9, 2017, through October 13, 2017 Medical Audit.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Kaiser SoCal Audit Review Period: September 1, 2017, through August 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in the Administrative and Organizational Capacity and State Supported Services categories during the October 2018 Medical and State Supported Services Audits of Kaiser SoCal.

Opportunities for Improvement—Compliance Reviews

Kaiser SoCal has the opportunity to work with DHCS to ensure that the MCP resolves all findings from the October 2018 Medical and State Supported Services Audits. The findings cut across the areas of quality and timeliness of, and access to, health care. Additionally, Kaiser SoCal has the opportunity to continue to work with DHCS to ensure that the MCP has fully addressed all findings from the October 2017 Medical Audit.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for Kaiser SoCal* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that Kaiser SoCal followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for Kaiser SoCal's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

[4] Quality Compass® is a registered trademark of NCQA.

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Kaiser SoCal—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	81.58%	81.57%	80.23%	78.35%	-1.88
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	98.25%	98.29%	98.63%	98.23%	-0.40

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	93.77%	91.55%	90.44%	89.75%	-0.69
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	94.28%	93.77%	92.41%	91.86%	-0.55
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	94.44%	94.33%	90.72%	90.44%	-0.28
Immunizations for Adolescents—Combination 2	—	34.06%	49.00%	57.30%	8.30
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	95.71%	94.73%	95.67%	94.18%	-1.49
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	97.16%	96.11%	96.84%	95.11%	-1.73

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.87%	71.68%	73.95%	71.06%	-2.89

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Kaiser SoCal—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	3	5	60.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	4	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	3	5	60.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Kaiser SoCal—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	84.58%	81.55%	82.64%	1.09
Cervical Cancer Screening	83.78%	83.35%	85.18%	84.52%	-0.66
Prenatal and Postpartum Care—Postpartum Care	77.42%	79.74%	77.33%	74.75%	-2.58
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.94%	93.10%	91.90%	92.53%	0.63

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Kaiser SoCal—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	3	3	100.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	2	100.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Kaiser SoCal—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.49%	94.06%	93.00%	90.86%	-2.14
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.73%	93.65%	93.27%	89.78%	-3.49
*Asthma Medication Ratio^*	—	87.76%	88.70%	89.23%	0.53
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	84.49%	82.82%	85.01%	84.66%	-0.35
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	84.56%	85.69%	83.67%	82.51%	-1.16

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	67.21%	65.54%	70.66%	69.96%	-0.70
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	19.85%	20.49%	18.52%	19.58%	1.06
*Comprehensive Diabetes Care—HbA1c Testing^*	95.55%	95.36%	95.19%	95.36%	0.17
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	95.33%	94.91%	94.02%	91.75%	-2.27
Controlling High Blood Pressure	—	—	—	84.78%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Kaiser SoCal—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	6	9	66.67%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	5	8	62.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	3	9	33.33%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Kaiser SoCal—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	32.50	28.81	29.99	30.70	Not Tested

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	490.40	489.16	499.73	510.10	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	51.67%	65.15%	76.54%	80.36%	3.82
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	24.73%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	87.30%	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	14.49%	Not Comparable
Use of Imaging Studies for Low Back Pain	84.88%	82.38%	87.05%	82.88%	-4.17

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Kaiser SoCal—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	2	100.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	2	100.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of Kaiser SoCal's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Kaiser SoCal—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	14	19	73.68%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Rates Above High Performance Levels for the Last Three or More Consecutive Years	11	16	68.75%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	6	19	31.58%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	19	0.00%

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table
Kaiser SoCal—San Diego County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.12.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	59.03	51.57	52.19	52.13	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	1010.07	951.91	938.40	959.26	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	93.45%	94.42%	92.65%	89.87%	-2.78
Annual Monitoring for Patients on Persistent Medications—Diuretics	94.77%	97.01%	92.13%	90.96%	-1.17
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	100.00%	100.0%	100.00%	100.00%	0.00
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	100.00%	100.0%	100.00%	100.00%	0.00

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	100.00%	100.0%	100.00%	100.00%	0.00
*Plan All-Cause Readmissions***	—	—	—	18.52%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
Kaiser SoCal—San Diego County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	27.81	25.02	26.22	26.93	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	398.43	412.14	425.13	431.22	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.14%	94.04%	93.02%	90.93%	-2.09
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.98%	93.39%	93.37%	89.68%	-3.69
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	98.24%	98.28%	98.62%	98.21%	-0.41
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	93.66%	91.40%	90.26%	89.55%	-0.71
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	94.11%	93.59%	92.19%	91.63%	-0.56

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	94.29%	94.18%	90.48%	90.19%	-0.29
*Plan All-Cause Readmissions***	—	—	—	13.14%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Kaiser SoCal—San Diego County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	52.13	26.93	Not Tested	30.70
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	959.26	431.22	Not Tested	510.10
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.87%	90.93%	-1.06	90.86%
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.96%	89.68%	1.28	89.78%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	98.21%	Not Comparable	98.23%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	100.00%	89.55%	10.45	89.75%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	100.00%	91.63%	8.37	91.86%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	100.00%	90.19%	9.81	90.44%
*Plan All-Cause Readmissions***	18.52%	13.14%	5.38	14.49%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that Kaiser SoCal stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, Kaiser SoCal had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly worse than the reporting year 2018 non-SPD rates for both *Annual Monitoring for Patients on Persistent Medications* measures.

- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates, the reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years,* and *12–19 Years* measures.

Strengths—Performance Measures

The HSAG auditor determined that Kaiser SoCal followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for Kaiser SoCal:

- Across all measures and domains, Kaiser SoCal performed above the high performance levels for 14 of 19 measures (74 percent), and the MCP had no measures with rates below the minimum performance levels.
  - Of the 16 measures for which the MCP reported rates for the last three or more consecutive years, 11 measures (69 percent) were above the high performance for the last three or more consecutive years.
  - The MCP performed above the high performance levels for all measures within the Preventive Screening and Women's Health domain.

Opportunities for Improvement—Performance Measures

Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, Kaiser SoCal has the opportunity to identify the causes for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate declining significantly from reporting year 2018 to reporting year 2019 and to develop strategies to address the identified causes.

Note the following:

- While the rates for both *Annual Monitoring for Patients on Persistent Medications* measures declined significantly from reporting year 2018 to reporting year 2019, HSAG makes no formal recommendations to the MCP related to these measures due to the small range of variation between the high performance level and minimum performance level thresholds for each measure.
- The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate declined significantly from reporting year 2018 to reporting year 2019. While Kaiser SoCal has opportunities for improvement related to this measure, HSAG makes no formal recommendations because DHCS will not require MCPs to report the measure to DHCS in

reporting year 2020, and DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCP's quality improvement actions related to the measure.

DHCS and HSAG expect that Kaiser SoCal will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCP will conduct improvement activities, as applicable, related to the *Annual Monitoring for Patients on Persistent Medications* and *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measures.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Kaiser SoCal's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Kaiser SoCal report rates for three HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for reporting years 2016 through 2019. The reporting year is the year in which the MLTSSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between reporting year 2018 and reporting year 2019. Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of those changes.

Table 4.1—Multi-Year MLTSSP Performance Measure Results
Kaiser SoCal—San Diego County

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's "contribution" to the total yearly membership.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	50.03	42.87	33.26	35.13	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	731.40	699.80	562.40	554.94	Not Tested
Medication Reconciliation Post-Discharge	89.58%	93.71%	86.82%	86.29%	-0.53

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure showed no statistically significant change from reporting year 2018 to reporting year 2019.

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, Kaiser SoCal conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required Kaiser SoCal to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, Kaiser SoCal identified depression screening among Hispanic and Latino beneficiaries ages 18 and older as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.1—Kaiser SoCal *Depression Screening* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of clinical depression screenings completed using an age-appropriate standardized tool among Hispanic or Latino beneficiaries ages 18 and older assigned to Kaiser Permanente Center A[6]	16.28%	33.00%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Depression Screening* Disparity PIP. Upon initial review of the module, HSAG determined that Kaiser SoCal met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Describing the priority-ranking process.

After receiving technical assistance from HSAG, Kaiser SoCal incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

[6] Center name removed for confidentiality.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Depression Screening* Disparity PIP, HSAG reviewed and provided feedback to Kaiser SoCal on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Kaiser SoCal that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.2 presents a description of the interventions that Kaiser SoCal tested for its *Depression Screening* Disparity PIP. The table also indicates the failure modes that each intervention addressed.

Table 5.2—Kaiser SoCal *Depression Screening* Disparity PIP Intervention Testing

Intervention	Failure Modes Addressed
Conduct Patient Health Questionnaire (PHQ) –2 depression screening on all Hispanic/Latino beneficiaries ages 18 years and older who have not been screened for depression within the past year.	♦ Current workflow does not address PHQ depression screening without active diagnosis of depression.
Contact beneficiaries by phone to complete PHQ–9 depression screening if physicians document initial depression diagnosis and depression screening was not completed during an office visit.	♦ Physicians document depression diagnosis code in electronic health records (EHRs), but PHQ–9 not completed. ♦ Physicians do not ask nurse to give patient PHQ–9 to complete.
Conduct culturally sensitive care training for providers and staff.	♦ Physicians do not assess for depression. ♦ Beneficiaries decline to complete PHQ–9 depression screening.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Kaiser SoCal to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although Kaiser SoCal completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Kaiser SoCal's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required Kaiser SoCal to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. However, based on Kaiser SoCal demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. Kaiser SoCal selected adolescent human papillomavirus (HPV) vaccinations as its 2017–19 DHCS-priority PIP topic based on its MCP-specific data.

Table 5.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.3—Kaiser SoCal *Adolescent Vaccinations* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of HPV two-dose or three-dose vaccination series completions among beneficiaries 13 years of age	49.9%	55.0%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the MCP's *Adolescent Vaccinations* PIP. Upon initial review of the module, HSAG determined that Kaiser SoCal met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Including all required components of the FMEA table.

After receiving technical assistance from HSAG, Kaiser SoCal incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Adolescent Vaccinations* PIP, HSAG reviewed and provided feedback to Kaiser SoCal on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Kaiser SoCal that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.4 presents a description of the interventions that Kaiser SoCal tested for its *Adolescent Vaccinations* PIP. The table also indicates the failure mode that each intervention addressed.

Table 5.4—Kaiser SoCal *Adolescent Vaccinations* PIP Intervention Testing

Intervention	Failure Modes Addressed
Implement new process to administer immunizations at non-well-care visits.	♦ Physicians do not identify when HPV vaccinations are due.
Improve workflow by identifying 10-year-old beneficiaries who are due for HPV vaccination and document vaccination due in EHRs.	♦ Medical assistants and nurses do not identify that HPV vaccinations are due for beneficiaries younger than 11 years old.
Conduct training for clinic nurse staff on how to communicate with parents/beneficiaries.	♦ Parents/beneficiaries decline HPV vaccinations for beneficiaries younger than 11 years old.
Schedule second HPV vaccine appointment prior to administering the first HPV vaccine.	♦ Face-to-face visit for second HPV vaccination is not scheduled prior to appointment departure.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Kaiser SoCal to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although Kaiser SoCal completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Kaiser SoCal's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, Kaiser SoCal submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on Kaiser SoCal's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

7. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

[7] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

8. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with Kaiser SoCal, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

9. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 9.1 provides EQR recommendations from Kaiser SoCal's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 9.1 to preserve the accuracy of Kaiser SoCal's self-reported actions.

Table 9.1—Kaiser SoCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP resolves all deficiencies from the October 2017 A&I Medical Audit.	Kaiser SoCal continues to work with DHCS' Managed Care Quality and Monitoring Division (MCQMD) to address the deficiencies identified from the October 2017 A&I Medical Audit. CAPs were submitted on April 27, 2018, and updates have been provided to MCQMD throughout the year as requested; the last update was submitted on March 25, 2019. The 2017 audit remains open as the MCP continues to make enhancements to increase compliance with Medi-Cal provider training requirements. The MCP has made significant improvement in this area and anticipates closure of the 2017 audit soon.
2. Monitor the adapted and adopted interventions to achieve optimal outcomes beyond the life of the 2015–17 *Diabetes* and *Initial Health Assessment Within 120 Days of Enrollment* PIPs, and apply lessons learned from these PIPs to facilitate improvement of the adapted and adopted interventions.	Kaiser SoCal continues to monitor *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* performance and the rate of initial health assessments (IHAs) completed within 120 days of enrollment. Monthly reports are published on the Kaiser Permanente intranet.

2017–18 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	Diabetes—Members with HbA1c <8.0 Percent Interventions: ♦ The PIP focused on improving HbA1c <8.0 percent at one primary care medical office site. Current San Diego service area-wide interventions are focused on achieving Kaiser SoCal's diabetes care goal to get each member on the path to self-management. ♦ Target chronically uncontrolled but motivated members through diabetes-focused visits with Primary Care Physician (PCP) Diabetes Champions, directing members to education programs, robust glucometer download processes, and weekly follow-up with diabetes complete care managers (CCMs). The diabetes CCMs continue to use a standardized workflow initiated during the PIP time frame that is based on motivational interviewing techniques and brief negotiation skills in discussion with patients, encouraging patient involvement in their plan of care. The PCP Diabetes Champion role includes leading diabetes measure performance and measure definition in primary care, serving as a liaison for regional diabetes strategy efforts, and providing content expertise and feedback to other PCPs in partnership with specialty areas such as Endocrinology, CCM, and the Positive Choice Integrative Wellness Center. ♦ Adherence to oral diabetes medication, medication for hypertension, and statins through pharmacy outreach and EHR tools that trigger physicians and advance practice providers to communicate with members with low supply remaining

2017–18 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	about medication adherence and filling prescriptions. **Initial Health Assessment Within 120 Days of Enrollment Interventions:** ♦ During the PIP time frame, a Kaiser SoCal Call Center agent completed three outreach phone calls to new members to select a primary care provider and schedule an IHA appointment, followed by a letter on the third failed attempt. As of February 2018, Kaiser SoCal revised the IHA outreach to align with the new Health Information Form/Member Evaluation Tool (HIF/MET) outreach process: ■ First Outreach: HIF/MET letter is sent via mail that asks the new member to select a primary care provider, schedule the IHA visit, and complete and return the HIF. ■ Second and Third Outreach: Automated follow-up robocalls. ■ Fourth Outreach: In-person phone call from a Virtual Medical Center Appointment Services Call Center representative to members who have not scheduled an IHA visit by 90 days. ♦ Call Center representatives continue the adopted PIP intervention of entering a telephone encounter in the member's EHR to notify physicians when outreach attempts were unsuccessful and a new member IHA is needed due to (1) member declining to schedule the appointment, (2) wrong or disconnected phone number, or (3) failed fourth and final attempt to contact the member.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Kaiser SoCal's self-reported actions in Table 9.1 and determined that Kaiser SoCal adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. Kaiser SoCal confirmed that the MCP is working with DHCS to ensure that the MCP resolves all deficiencies from the October 2017 A&I Medical Audit and noted that it anticipates DHCS will be closing the CAP soon. Kaiser SoCal also provided details about how the MCP continues to build on the interventions it tested as part of the MCP's 2015–17 *Diabetes* and *Initial Health Assessment Within 120 Days of Enrollment* PIPs.

2018–19 Recommendations

Based on the overall assessment of Kaiser SoCal's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to ensure that the MCP resolves all findings from the October 2018 Medical and State Supported Services Audits.
- Continue to work with DHCS to ensure that the MCP has fully addressed all findings from the October 2017 Medical Audit.
- Identify the causes for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate declining significantly from reporting year 2018 to reporting year 2019 and develop strategies to address the identified causes.

In the next annual review, HSAG will evaluate continued successes of Kaiser SoCal as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix X:
Performance Evaluation Report
L.A. Care Health Plan
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §348.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, L.A. Care Health Plan ("L.A. Care" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in L.A. Care's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

L.A. Care is a full-scope MCP delivering services to beneficiaries as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in L.A. Care, the Local Initiative MCP; or in Health Net Community Solutions, Inc., the alternative commercial plan.

L.A. Care became operational in Los Angeles County to provide MCMC services effective March 1997. As of June 2019, L.A. Care had 2,018,523 beneficiaries in Los Angeles County.[1] This represents 68 percent of the beneficiaries enrolled in Los Angeles County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for L.A. Care. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of L.A. Care. A&I conducted the audits from September 10, 2018, through September 21, 2018.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of L.A. Care
Audit Review Period: July 1, 2017, through June 30, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	No	No findings.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	No	No findings.
Administrative and Organizational Capacity	Yes	CAP imposed and findings in this category rectified.
State Supported Services	No	No findings.

Follow-Up on 2017 A&I Medical Audit

A&I conducted Medical and State Supported Services Audits of L.A. Care from September 18, 2017, through September 29, 2017, covering the review period of July 1, 2016, through June 30, 2017. HSAG provided a summary of the audit results and status in L.A. Care's 2017–18 MCP-specific evaluation report. At the time of the 2017–18 MCP-specific evaluation report publication, L.A. Care's CAP was in progress and under review by DHCS. A letter from DHCS dated September 5, 2018, stated that L.A. Care provided DHCS with additional information regarding the CAP and that DHCS had found all items to be in compliance; therefore, DHCS closed the CAP.

Strengths—Compliance Reviews

Based on information submitted to DHCS by L.A. Care, DHCS closed the MCP's CAPs from the 2017 and 2018 A&I Medical and State Supported Services Audits.

Opportunities for Improvement—Compliance Reviews

L.A. Care has no outstanding findings from the 2017 and 2018 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for L.A. Care Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that L.A. Care followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for L.A. Care's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

[4] Quality Compass® is a registered trademark of NCQA.

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
L.A. Care—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	73.61%	71.50%	70.56%	72.26%	1.70
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**90.11%**	**93.04%**	**91.44%**	**91.93%**	0.49

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**83.75%**	**83.69%**	**83.94%**	**83.97%**	0.03
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**88.59%**	**87.35%**	89.14%	88.22%	-0.92
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**85.04%**	**83.80%**	86.49%	**85.61%**	-0.88
Immunizations for Adolescents—Combination 2	—	28.26%	39.66%	42.82%	3.16
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	76.76%	77.69%	83.61%	85.28%	1.67

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	68.52%	68.04%	74.44%	83.61%	9.17
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.43%	78.49%	74.65%	74.45%	-0.20

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
L.A. Care—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	5	40.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
L.A. Care—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	59.31%	59.53%	60.98%	1.45
Cervical Cancer Screening	57.63%	59.31%	60.55%	66.08%	5.53
Prenatal and Postpartum Care—Postpartum Care	**55.23%**	56.17%	**56.54%**	62.72%	6.18
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**74.21%**	75.06%	82.22%	87.90%	5.68

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings L.A. Care—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	3	66.67%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Assessment of Improvement Plans—Preventive Screening and Women's Health

Based on reporting year 2018 performance measure results, DHCS required L.A. Care to submit an IP for the *Prenatal and Postpartum Care—Postpartum Care* measure. L.A. Care conducted two PDSA cycles to help improve the MCP's performance on this measure.

Plan-Do-Study-Act Cycle 1

L.A. Care tested whether having the MCP's outreach coordinator contact beneficiaries to schedule their postpartum care visits and having the MCP's medical director contact the clinics

to request that they conduct outreach to those beneficiaries whom the outreach coordinator was unable to reach would increase the number of beneficiaries being seen for their postpartum care appointment. L.A. Care abandoned this intervention and planned to conduct outreach via text messaging instead of by phone.

Plan-Do-Study-Act Cycle 2

To address the perceived barrier of providers not sharing medical records with the vendor, L.A. Care contacted the providers to obtain the medical records on behalf of the vendor. Through the process of conducting the PDSA cycle, L.A. Care learned that incorrect provider information was the issue rather than providers unwilling to share medical records with the vendor.

The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure improved to above the minimum performance level in reporting year 2019.

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
L.A. Care—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.12%	88.17%	88.96%	88.61%	-0.35

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.40%	87.67%	88.33%	88.06%	-0.27
*Asthma Medication Ratio^*	—	57.58%	62.09%	60.90%	-1.19
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	58.55%	60.04%	65.21%	70.80%	5.59
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	58.00%	54.74%	63.26%	64.72%	1.46
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	47.09%	48.72%	51.09%	51.09%	0.00
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	41.64%	39.96%	35.52%	35.28%	-0.24
*Comprehensive Diabetes Care—HbA1c Testing^*	86.00%	87.77%	86.37%	86.13%	-0.24
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	94.36%	92.15%	92.70%	90.51%	-2.19
Controlling High Blood Pressure	—	—	—	71.05%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
L.A. Care—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent

services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.

- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
L.A. Care—Los Angeles County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	40.61	39.71	41.18	41.56	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	345.93	295.32	351.53	402.02	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	29.66%	31.51%	33.63%	35.54%	1.91
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	0.03%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	27.50%	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	21.50%	Not Comparable
Use of Imaging Studies for Low Back Pain	78.01%	74.61%	72.41%	71.74%	-0.67

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings L.A. Care—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of L.A. Care's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
L.A. Care—Los Angeles County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	19	10.53%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	4	19	21.05%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	18	0.00%

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table
L.A. Care—Los Angeles County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.12.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	70.03	68.17	60.66	67.69	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	621.22	557.34	583.04	723.39	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.33%	89.83%	90.94%	90.14%	-0.80
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.32%	90.16%	90.95%	90.41%	-0.54
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	92.16%	93.85%	80.85%	87.79%	6.94
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	84.06%	86.06%	86.00%	87.14%	1.14
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	88.15%	88.49%	91.86%	90.45%	-1.41

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	83.04%	83.44%	87.05%	86.75%	-0.30
*Plan All-Cause Readmissions***	—	—	—	29.30%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
L.A. Care—Los Angeles County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	37.56	37.14	39.16	39.59	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	317.46	271.67	327.50	377.88	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.35%	87.21%	87.95%	88.03%	0.08
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.13%	86.13%	86.93%	87.06%	0.13
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	90.09%	93.04%	91.52%	91.96%	0.44
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.74%	83.62%	83.88%	83.88%	0.00
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	88.61%	87.29%	89.01%	88.12%	-0.89
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	85.17%	83.82%	86.46%	85.55%	-0.91
*Plan All-Cause Readmissions***	—	—	—	17.32%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations L.A. Care—Los Angeles County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	67.69	39.59	Not Tested	41.56
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	723.39	377.88	Not Tested	402.02
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.14%	88.03%	2.11	88.61%
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.41%	87.06%	3.35	88.06%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	87.79%	91.96%	-4.17	91.93%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.14%	83.88%	3.26	83.97%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	90.45%	88.12%	2.33	88.22%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	86.75%	85.55%	1.20	85.61%
*Plan All-Cause Readmissions***	29.30%	17.32%	11.98	21.50%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that L.A. Care stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 SPD rates were significantly worse than the reporting year 2018 SPD rates for the following measures:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*.
  - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly worse than the reporting year 2018 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* measures.
- The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
  - Both *Annual Monitoring for Patients on Persistent Medications* measures.
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*.
- The reporting year 2019 SPD rates were significantly worse than the reporting year 2019 non-SPD rates for the following measures:
  - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*. The significant difference in the rate for this measure may be attributed to beneficiaries in this age group in the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from primary care providers (PCPs).
  - *Plan All-Cause Readmissions*. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that L.A. Care followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for L.A. Care:

- L.A. Care had no measures with rates below the minimum performance levels.
- The rates for both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures were above the high performance levels.
- The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure moved from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019.
- Across all domains, the rates for the following four of 19 measures (21 percent) improved significantly from reporting year 2018 to reporting year 2019:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
  - *Breast Cancer Screening*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total*

Opportunities for Improvement—Performance Measures

Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, L.A. Care has the opportunity to identify the causes for the *Asthma Medication Ratio* measure rate declining significantly from reporting year 2018 to reporting year 2019 and to develop strategies, as applicable, to address the significant decline. Note that NCQA made specification changes in reporting year 2019 for the *Asthma Medication Ratio* measure; therefore, the significant decline in this measure's rate may be due to NCQA's specification changes and may not be related to L.A. Care's performance.

While the rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure declined significantly from reporting year 2018 to reporting year 2019, HSAG makes no formal recommendations to the MCP related to this measure due to the small range of variation between the high performance level and minimum performance level thresholds for the measure.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to L.A. Care's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that L.A. Care report rates for three HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for reporting years 2016 through 2019. The reporting year is the year in which the MLTSSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between reporting year 2018 and reporting year 2019. Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of those changes.

Table 4.1—Multi-Year MLTSSP Performance Measure Results
L.A. Care—Los Angeles County

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's "contribution" to the total yearly membership.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	59.09	60.61	55.44	54.53	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	538.37	495.85	544.74	636.89	Not Tested
Medication Reconciliation Post-Discharge	11.68%	20.92%	16.55%	24.09%	7.54

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure improved significantly from reporting year 2018 to reporting year 2019.

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, L.A. Care conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required L.A. Care to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, L.A. Care identified diabetes medication adherence among African-American beneficiaries as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.1—L.A. Care *Diabetes Medication Adherence* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of proportion of days covered for diabetes medication of less than 0.8 among African-American beneficiaries, ages 35 to 45, who are not assigned to L.A. County Department of Health Services clinics.	54%	38%

Intervention Testing

Table 5.2 presents a description of the intervention that L.A. Care tested for its *Diabetes Medication Adherence* Disparity PIP. The table also indicates the failure mode that the intervention addressed.

Table 5.2—L.A. Care *Diabetes Medication Adherence* Disparity PIP Intervention Testing

Intervention	Failure Mode Addressed
Contacting beneficiaries by phone who have missed at least one refill to: ♦ Address any barriers. ♦ Inform them about the mail order program in which beneficiaries can receive a 90-day supply of medication. ♦ Attempt to secure refills.	♦ Beneficiaries are not aware of what to do when they reach the maximum number of refills.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to L.A. Care and conducted technical assistance calls with MCP staff members to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although L.A. Care completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in L.A. Care's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required L.A. Care to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, L.A. Care selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.3—L.A. Care *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of *Childhood Immunization Status—Combination 3* measure in San Gabriel Valley	40.9%	51.0%

Intervention Testing

Table 5.4 presents a description of the intervention that L.A. Care tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the failure modes that the intervention addressed.

Table 5.4—L.A. Care *Childhood Immunization Status—Combination 3* PIP Intervention Testing

Intervention	Failure Modes Addressed
Offering assistance to provider offices that do not actively use the California Immunization Registry—focusing on connecting electronic health record systems to the California Immunization Registry and/or coaching staff members on data entry and use of the California Immunization Registry	♦ Provider does not enter data into the California Immunization Registry. ♦ Provider does not participate in the California Immunization Registry.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to L.A. Care to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although L.A. Care completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in L.A. Care's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, L.A. Care submitted to HSAG all required documentation about planned interventions during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on L.A. Care's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

7. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[6] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

[6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

8. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with L.A. Care, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

9. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 9.1 provides EQR recommendations from L.A. Care's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 9.1 to preserve the accuracy of L.A. Care's self-reported actions.

Table 9.1—L.A. Care's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP resolves all deficiencies from the September 2017 A&I Medical and State Supported Services Audits.	As a result of the 2017 DHCS Medical Audit, L.A. Care enhanced existing processes in these ways: ♦ Developed a formal and systematic Behavioral Health Team Utilization Management process within our utilization management system to approve Behavioral Health Team plans. ♦ Implemented an internal quality assurance process wherein provider data are reviewed for data integrity using business rules. ♦ Enhanced the Potential Quality Incident (PQI) process by creating a more robust PQI criteria guideline and ongoing training. In addition, we began to require our behavioral health vendor delegated for quality improvement to submit quarterly PQI reports, undergo annual PQI delegation audits, and report quality improvement updates to our Behavioral Health Quality Improvement Committee meetings. Our quality improvement team

2017–18 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	conducts annual analysis of all PQIs and reviews trends identified. ♦ Developed a policy to ensure we notify DHCS of a new chief medical officer within 10 working days. ♦ Modified our process to ensure all suspected fraud and abuse cases are reported to DHCS in a timely manner and timeliness is monitored on an ongoing basis.
2. Increase the MCP's medical record abstraction oversight to ensure medical record abstraction accuracy.	In 2018, L.A. Care contracted with two medical record abstraction vendors. One of the vendors had significant error rates making abstraction oversight and follow-up for that vendor time-consuming. In 2019, L.A. Care did not use the underperforming vendor, and the remaining vendor had a history of abstraction accuracy above 98 percent. In addition, L.A. Care allocated additional resources to allow for review of 100 percent of vendor abstractions.
3. To address the MCP's performance below the minimum performance level in RY 2018 for the *Prenatal and Postpartum Care—Postpartum Care* measure, identify strategies to increase the percentage of female beneficiaries who deliver a live birth and complete a postpartum visit on or between 21 and 56 days after delivery.	♦ In 2018, L.A. Care staged an intervention in which a staff member called the offices of the obstetricians/gynecologists (OB/GYNs) of women who had given birth between September 24, 2018, and December 14, 2018, but had not been reachable by phone. The OB/GYN office staff members were asked to facilitate scheduling an appointment for postpartum care within 21 to 56 days of delivery. L.A. Care believed this intervention would improve upon an existing incentive campaign by increasing the coordination of care for new mothers between the MCP and the provider. L.A. Care also believed that members who did not answer calls from L.A. Care may be more likely to respond to calls from their OB/GYN.

2017–18 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	♦ Ultimately, providers faced similar difficulties in reaching members and convincing them to come in for postpartum care. By the end of the intervention, only four appointments had been scheduled. L.A. Care decided that based on this response, it would be better to focus efforts in an area other than telephone outreach, and we will not be continuing this intervention. ♦ For the second PDSA intervention, tested in March through May 2019, L.A. Care staff members conducted additional outreach to provider offices that had not responded to chart requests for the hybrid review of the *Postpartum Care* measure. This intervention was selected because in HEDIS 2018, 5 percent of noncompliant cases were due to nonresponse to requests for medical records from provider offices. Out of 66 record chases targeted in the intervention, we were able to retrieve 47 (71 percent) charts. Nine offices (14 percent) indicated that no chart was available, and 10 providers (15 percent) could not be reached. We determined that this intervention was successful and that it contributed to the 6.17 percentage point increase in the measure, meeting the minimum performance level. L.A. Care plans to continue this intervention.

2017–18 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
4. Assess the causes for the rate declining significantly from RY 2017 to RY 2018 for the *All-Cause Readmissions* measure; and identify strategies to prevent, to the highest degree possible, unplanned acute readmissions within 30 days of discharge for beneficiaries 21 years and older.	A year-over-year 30-day readmission rate decline of 1.93 percentage points is consistent with a Medi-Cal year-over-year enrollment increase of 3 percent for December 2016 compared to December 2017. A monitoring report based on year-to-date performance of the *Plan All-Cause Readmissions* measure has been introduced starting in 2019. This report includes the details of the readmissions that occurred and goes to independent physician associations for monitoring purposes. The measure has also been incorporated into the Medi-Cal pay-for-performance incentive program. Utilization management strategies to mitigate 30-day readmissions include the following: ♦ Launch a Transitions of Care (TOC) Program for high-risk members ♦ Fully engage the new tool, Impact Pro, to provide historical data and risk-predicting analytics to enroll members in TOC ♦ Hire a medical social worker to support TOC and other utilization management programs ♦ Increase referrals to case management for longer-term interventions

2017–18 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
5. Evaluate the effect the tools that the MCP developed to identify and manage low back pain had on the rate for the *Use of Imaging Studies for Low Back Pain* measure; and, if applicable, modify improvement strategies to address the MCP's continued declining performance on this measure.	♦ A Low Back Pain Treatment Pocket Guide was mailed to the offices of high-volume, low-performing PCPs in July 2018. The guide is provider educational material developed in the Chronic Care Work Group that includes an at-a-glance algorithm flyer, *Back Pain in Adults: Guidelines for Diagnosis and Treatment,* and a patient questionnaire scoring tool pocket card, *The Keele STarT Back Screening Tool*. This information was also incorporated into our Clinical Practice Guidelines. ♦ In evaluating the effectiveness of the intervention, L.A. Care determined that 9 percent of the targeted providers showed statistically significant improvement and 49 percent showed any improvement in measurement year 2018 compared to measurement year 2017. In further review of the outcomes, it was determined that the target list for the 2018 intervention was pulled incorrectly; because this is an inverted measure, the high-performing providers were mistakenly identified as low-performing. Still, the results for the high-performing group seem encouraging. L.A. Care plans to repeat this intervention in the coming weeks for low-performing providers and will evaluate outcomes in 2020. ♦ Unfortunately, the HEDIS 2019 *Use of Imaging Studies for Low Back Pain* measure rate declined by 0.67 percentage points from the previous year, but this was not a statistically significant change. The denominator for *Use of Imaging Studies for Low Back Pain* increased by 26 percent from the previous year; we believe the positive impact of the interventions was mitigated by the increase in denominator.

2017–18 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	We plan to continue the intervention in Quarter 3, 2019.
6. Incorporate lessons learned from the 2015–17 *Immunizations of Two-Year-Olds* PIP into the MCP's 2017–19 *Childhood Immunization Status—Combination 3* PIP.	♦ The primary challenge to the 2015–17 *Childhood Immunization Status—Combination 3* PIP was maintaining ongoing engagement with the partnering provider. For the 2017–19 PIP, we initially sought partnership with the provider group that held most of the contracts in the target region; however, it became clear after initial conversations that the partner group was not fully invested in the project. To avoid the pitfalls of the previous PIP, L.A. Care chose to lead efforts and take responsibility for data management and intervention activities. ♦ While the 2015–17 PIP focused on intervening at a federally qualified health center, L.A. Care chose to work directly with solo and small group practices to test effectiveness for the 2017–19 PIP. When coaching these offices on the opportunities related to immunization, we emphasized potential incentive payments, which was a lesson learned from the previous PIP.
7. Apply the lessons learned from both 2015–17 *Immunizations of Two-Year-Olds* and *Medication Management for People With Asthma* PIPs to facilitate improvement for future PIPs.	♦ The primary challenge for both 2015–17 PIPs was maintaining ongoing engagement with the partnering providers. To avoid this issue in the 2017–19 PIPs, L.A. Care chose to retain most to all of the responsibility for the interventions and data management. While this was more resource-intensive for our quality improvement team, it allowed us to control the implementation of the intervention, resulting in timely launches and more timely access to the data. ♦ We also purposely selected SMART Aims based on more reliable and frequently updated data sources for the 2017–19

2017–18 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	PIPs. In previous PIPs we found that standard clinical data came in too slowly and receiving data directly from the partnering providers was not consistent or reliable. For 2017–19, we selected internal pharmacy data and California Immunization Registry downloads, both of which are refreshed monthly, because of the importance of using timely data sources, a lesson learned from the previous PIPs.

Assessment of MCP's Self-Reported Actions

HSAG reviewed L.A Care's self-reported actions in Table 9.1 and determined that L.A. Care adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. L.A. Care described in detail actions taken during the review period, lessons learned, and steps the MCP plans to take moving forward. The self-reported actions L.A. Care described in Table 9.1 may have contributed to the improvement in the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure, resulting in the rate for this measure moving from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019.

2018–19 Recommendations

Based on the overall assessment of L.A. Care's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that the MCP identify the causes for the *Asthma Medication Ratio* measure rate declining significantly from reporting year 2018 to reporting year 2019 and develop strategies, as applicable, to address the significant decline.

In the next annual review, HSAG will evaluate continued successes of L.A. Care as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix Y:
Performance Evaluation Report
LIBERTY Dental Plan of California, Inc.
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS' contracted Medi-Cal dental managed care (DMC) plan, LIBERTY Dental Plan of California, Inc. ("LIBERTY Dental" or "the DMC plan"). The purpose of this appendix is to provide DMC-specific results of each activity and an assessment of the DMC plan's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to dental care services furnished to Medi-Cal Managed Care (MCMC) beneficiaries (referred to as "beneficiaries" in this report). The review period for this DMC plan-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in LIBERTY Dental's 2019–20 MCP-specific evaluation report. This DMC plan-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and all managed care health plan (MCP), population-specific health plan (PSP), specialty health plan (SHP), and DMC plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCPs, PSPs, SHPs, and DMC plans are providing to beneficiaries.

Medi-Cal Dental Managed Care Plan Overview

LIBERTY Dental operates in Los Angeles County as a Prepaid Health Plan (PHP) and in Sacramento County under a Geographic Managed Care (GMC) model. In Los Angeles County beneficiaries have the option of enrolling in a DMC plan or accessing dental benefits through the dental fee-for-service (FFS) delivery system, whereas in Sacramento County DMC enrollment is mandatory.

LIBERTY Dental became operational as a DMC plan in Los Angeles County effective July 1, 2013, and in Sacramento County effective January 1, 2013. As of June 2019, LIBERTY Dental had 62,077 beneficiaries in Los Angeles County and 163,456 in Sacramento County—for a total of 225,533 beneficiaries.[1] This represents 16 percent of the DMC beneficiaries enrolled in Los Angeles County and 39 percent of DMC beneficiaries enrolled in Sacramento County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Dental Managed Care Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for LIBERTY Dental. The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes results and status of the Department of Managed Health Care (DMHC) Routine Survey of LIBERTY Dental. DMHC conducted the on-site survey from January 14, 2014, through January 17, 2014. While DMHC conducted the survey outside the review period for this DMC plan-specific evaluation report, HSAG includes the information because it is the most recent survey conducted by DMHC.

Table 2.1—2014 DMHC Routine Survey of LIBERTY Dental

Category Evaluated	Deficiencies/ Findings (Yes/No)	Monitoring Status
Section I: Knox-Keene Survey		
Quality Management	No	Not applicable.
Grievances and Appeals	No	Not applicable.
Access and Availability of Services	No	Not applicable.
Utilization Management	No	Not applicable.
Language Assistance	No	Not applicable.
Section II: Medi-Cal Dental Managed Care Survey		
Access and Availability	No	Not applicable.
Grievance and Appeals Policy and Procedures	No	Not applicable.
Quality Management	Yes	The DMC plan corrected the deficiencies prior to DMHC issuing the final survey report.
Utilization Management	No	Not applicable.

Strengths—Compliance Reviews

While DMHC identified one finding in the Quality Management category and one finding related to general contract requirements during the January 2014 Routine Survey of LIBERTY Dental, the DMC plan corrected the deficiencies prior to DMHC issuing the final survey report.

Opportunities for Improvement—Compliance Reviews

LIBERTY Dental has no outstanding findings from the January 2014 DMHC Routine Survey; therefore, HSAG has no recommendations for the DMC plan in the area of compliance reviews.

3. Dental Managed Care Plan Performance Measures

DHCS requires DMC plans to submit quarterly self-reported performance measure rates for each reporting unit (i.e., Los Angeles County and Sacramento County). To provide ongoing, consistent comparison over time, DMC plans use a rolling 12-month methodology to display rates for a full year within each quarterly performance measure rate report.

Reporting year 2019 was the first year that DHCS required DMC plans to submit both reporting units' audited performance measure rates reflecting measurement year (MY) data from the previous calendar year. In April 2019, LIBERTY Dental submitted both reporting units' reporting year 2019 performance measure rates reflecting measurement year 2018 data (i.e., January 1, 2018, through December 31, 2018).

Performance Measure Results

Table 3.1 and Table 3.2 present LIBERTY Dental's reporting year 2019 audited performance measure rates for each DMC plan reporting unit. To allow HSAG to provide a meaningful display of DMC plan performance, HSAG organized the performance measures according to the health care areas that each measure affects (i.e., Access to Care and Preventive Care).

Note that HSAG could not compare reporting year 2019 DMC plan performance measure rates to historical data or DHCS' encounter data since reporting year 2019 was the first year that DMC plans were required to report audited performance measure rates; therefore, HSAG makes no conclusions or recommendations related to DMC plans' reporting year 2019 performance measure results.

Table 3.1—Reporting Year 2019 (Measurement Year 2018) Dental Managed Care Plan Performance Measure Results
LIBERTY Dental—Los Angeles County

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Measure	Reporting Year 2019 Rate
Access to Care	
Annual Dental Visits—0–20 Years	39.7%
Annual Dental Visits—21+ Years	21.3%
Continuity of Care—0–20 Years	65.2%
Continuity of Care—21+ Years	36.4%

Measure	Reporting Year 2019 Rate
Exam/Oral Health Evaluations—0–20 Years	35.6%
Exam/Oral Health Evaluations—21+ Years	17.2%
General Anesthesia—0–20 Years	46.6%
General Anesthesia—21+ Years	33.9%
Overall Utilization of Dental Services–One Year—0–20 Years	44.2%
Overall Utilization of Dental Services–One Year—21+ Years	21.2%
Use of Dental Treatment Services—0–20 Years	17.3%
Use of Dental Treatment Services—21+ Years	13.3%
Usual Source of Care—0–20 Years	33.9%
Usual Source of Care—21+ Years	9.5%
Preventive Care	
Preventive Services to Filling—0–20 Years	81.8%
Preventive Services to Filling—21+ Years	31.1%
Sealants to Restoration Ratio (Surfaces)—6–9 Years	5.8
Sealants to Restoration Ratio (Surfaces)—10–14 Years	2.1
Treatment/Prevention of Caries—0–20 Years	24.5%
Treatment/Prevention of Caries—21+ Years	7.3%
Use of Preventive Services—0–20 Years	34.4%
Use of Preventive Services—21+ Years	9.4%
Use of Sealants—6–9 Years	13.2%
Use of Sealants—10–14 Years	6.3%

Table 3.2—Reporting Year 2019 (Measurement Year 2018) Dental Managed Care Plan Performance Measure Results
LIBERTY Dental—Sacramento County

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Measure	Reporting Year 2019 Rate
Access to Care	
Annual Dental Visits—0–20 Years	42.4%
Annual Dental Visits—21+ Years	22.6%
Continuity of Care—0–20 Years	67.0%
Continuity of Care—21+ Years	34.0%
Exam/Oral Health Evaluations—0–20 Years	37.0%
Exam/Oral Health Evaluations—21+ Years	16.5%
General Anesthesia—0–20 Years	68.5%
General Anesthesia—21+ Years	34.3%
Overall Utilization of Dental Services–One Year—0–20 Years	49.4%
Overall Utilization of Dental Services–One Year—21+ Years	24.9%
Use of Dental Treatment Services—0–20 Years	25.0%
Use of Dental Treatment Services—21+ Years	16.4%
Usual Source of Care—0–20 Years	37.5%
Usual Source of Care—21+ Years	12.3%
Preventive Care	
Preventive Services to Filling—0–20 Years	84.0%
Preventive Services to Filling—21+ Years	35.0%
Sealants to Restoration Ratio (Surfaces)—6–9 Years	5.8
Sealants to Restoration Ratio (Surfaces)—10–14 Years	2.2
Treatment/Prevention of Caries—0–20 Years	30.1%
Treatment/Prevention of Caries—21+ Years	8.7%
Use of Preventive Services—0–20 Years	35.7%
Use of Preventive Services—21+ Years	8.3%
Use of Sealants—6–9 Years	17.0%
Use of Sealants—10–14 Years	9.4%

4. Performance Improvement Projects

DHCS requires DMC plans to conduct two quality improvement projects (QIPs) per year. DMC plans must participate in a DHCS-established and facilitated statewide QIP as well as an individual QIP that aligns with a demonstrated area in need of improvement.

Prior to January 2019, DHCS required DMC plans to submit quarterly progress reports for both the statewide and individual QIPs. After discussions with HSAG in January and February of 2019, DHCS modified the requirements for DMC plans. Beginning in February 2019, DHCS required DMC plans to submit two reports annually for the statewide QIP—one intervention progress report to HSAG, and an annual QIP submission to DHCS. Additionally, DHCS required DMC plans to begin conducting their individual QIPs using HSAG's rapid-cycle PIP process. With the transition of DMC plans' individual QIPs to HSAG's rapid-cycle PIP process, HSAG began referring to DMC plans' individual QIPs as individual performance improvement projects (PIPs).

Statewide Quality Improvement Project

DHCS requires DMC plans to conduct statewide QIPs focused on *Preventive Services Utilization*. The goals of the statewide QIP are to increase preventive services among children ages 1 to 20 by 10 percentage points by the end of 2023.

Based on the new reporting requirements, LIBERTY Dental participated in HSAG's Statewide QIP Intervention Progress Report Overview webinar in March 2019 to obtain information on the report submission requirements. LIBERTY Dental submitted the health plan's first intervention progress report to HSAG in April 2019. The DMC plan reported on identified barriers and interventions conducted as of March 31, 2019. In May 2019, HSAG provided feedback to LIBERTY Dental on the intervention progress report, including the following:

- LIBERTY Dental provided a key driver diagram, a description of the DMC plan's causal barrier processes and rankings, and intervention implementation and evaluation information.
- The DMC plan should rank the barriers in order of priority and revisit the casual/barrier analysis and priority ranking process at least annually.
- The DMC plan logically linked the interventions to identified barriers and implemented the interventions in a timely manner to directly impact study indicator outcomes.
- The DMC plan provided next steps for the intervention based on intervention evaluation data.

Individual Performance Improvement Project

Based on DHCS' new requirements, the DMC plan began to conduct its individual PIP using HSAG's rapid-cycle PIP process. LIBERTY Dental selected dental care among beneficiaries living with diabetes as its individual PIP topic. In April 2019, LIBERTY Dental participated in HSAG's rapid-cycle PIP process overview training session to obtain general background about the key concepts of the rapid-cycle PIP framework as well as submission requirements for modules 1 through 5 and HSAG's PIP validation process.

During the review period for this DMC-specific evaluation report, LIBERTY Dental did not progress to submitting any PIP modules for HSAG to validate. Therefore, HSAG includes no validation findings in this report. HSAG will include a summary of the DMC plan's *Dental Care among Beneficiaries Living with Diabetes* PIP activities and validation findings in LIBERTY Dental's 2019–20 DMC-specific evaluation report.

Strengths—Performance Improvement Projects

LIBERTY Dental successfully completed the first intervention progress report for the *Preventive Services Utilization* statewide QIP, providing all requested information. The DMC plan also provided all required information to support its *Dental Care among Beneficiaries Living with Diabetes* individual PIP topic selection.

Opportunities for Improvement—Performance Improvement Projects

Based on LIBERTY Dental's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Recommendations

Based on the overall assessment of LIBERTY Dental's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the DMC plan.

In the next annual review, HSAG will evaluate continued successes of LIBERTY Dental.

Appendix Z:
Performance Evaluation Report
Molina Healthcare of California Partner Plan, Inc.
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Molina Healthcare of California Partner Plan, Inc. ("Molina" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in Molina's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

In Riverside and San Bernardino counties, Molina is a full-scope MCP delivering services to beneficiaries as a commercial plan (CP) under the Two-Plan Model. Beneficiaries may enroll in Molina, the CP; or in Inland Empire Health Plan, the alternative "local initiative".

In Sacramento and San Diego Counties, Molina delivers services to beneficiaries under a Geographic Managed Care (GMC) model. The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

In addition to Molina, Sacramento County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Anthem Blue Cross Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser NorCal

In addition to Molina, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Shield of California Promise Health Plan (known as Care1st Partner Plan prior to January 1, 2019)
- Community Health Group Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser SoCal
- UnitedHealthcare Community Plan

In Imperial County, Molina delivers services to beneficiaries under the Imperial model. Beneficiaries may enroll in Molina or California Health and Wellness Plan, the other CP.

Molina became operational in Riverside and San Bernardino counties to provide MCMC services effective December 1997. DHCS allows Molina to combine data for Riverside and San Bernardino counties for reporting purposes. For this report, Riverside and San Bernardino counties represent a single reporting unit.

Molina expanded to Sacramento County in 2000 and San Diego County in 2005. The MCP began providing services in Imperial County effective November 1, 2013.

Table 1.1 shows the number of beneficiaries for Molina for each county, the percentage of beneficiaries enrolled in the county, and the CMP's total number of beneficiaries as of June 2019.[1]

Table 1.1—Molina Enrollment as of June 2019

* Note that DHCS allows Molina to report Riverside and San Bernardino counties as a combined (i.e., single reporting unit) rate.

County	Enrollment as of June 2019	Percentage of Beneficiaries Enrolled in the County
Imperial	14,269	19%
Riverside*	80,964	12%
Sacramento	50,494	12%
San Bernardino*	65,728	10%
San Diego	216,390	31%
Total	427,845	

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Molina. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Molina. A&I conducted the audits from July 30, 2018, through August 3, 2018.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Molina
Audit Review Period: July 1, 2017, through June 30, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	No	No findings.
Quality Management	No	No findings.
State Supported Services	No	No findings.

Follow-Up on 2017 A&I Medical Audit

A&I conducted an on-site Medical Audit of Molina from August 7, 2017, through August 11, 2017, covering the review period of August 1, 2016, through July 31, 2017. HSAG provided a summary of the audit results and status in Molina's 2017–18 MCP-specific evaluation report. At the time of the 2017–18 MCP-specific evaluation report publication, Molina's CAP was in progress and under review by DHCS. A letter from DHCS dated October 19, 2018, stated that Molina provided DHCS with additional information regarding the CAP, that DHCS accepted the MCP's submitted CAP, and that DHCS had therefore closed the CAP.

Strengths—Compliance Reviews

A&I identified no findings in the Case Management and Coordination of Care, Member's Rights, Quality Management, and State Supported Services categories during the July 30, 2018, through August 3, 2018, Medical and State Supported Services Audits of Molina. Additionally, Molina fully resolved all outstanding findings from the August 2017 A&I Medical Audit.

Opportunities for Improvement—Compliance Reviews

Molina has the opportunity to work with DHCS to ensure that the MCP fully resolves all findings from the July 30, 2018, through August 3, 2018, Medical and State Supported Services Audits.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for Molina Healthcare of California Partner Plan, Inc.* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that Molina followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.36 for Molina's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.36:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.32 present the performance measure results and findings by domain, and Table 3.33 through Table 3.36 present the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.
- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 through Table 3.4 present the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1 through Table 3.4:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

[4] Quality Compass® is a registered trademark of NCQA.

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Molina—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**56.96%**	64.35%	66.67%	70.56%	3.89
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**83.56%**	93.16%	**91.24%**	94.47%	3.23

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**76.48%**	**76.50%**	**75.37%**	**82.57%**	7.20
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**81.59%**	**76.30%**	**73.91%**	**75.03%**	1.12
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**79.95%**	**73.34%**	**72.93%**	**73.38%**	0.45
Immunizations for Adolescents—Combination 2	—	19.61%	25.45%	29.96%	4.51
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	75.72%	75.06%	71.05%	73.48%	2.43

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	71.96%	67.99%	70.80%	75.67%	4.87
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**61.81%**	71.52%	67.88%	73.97%	6.09

Table 3.2—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Molina—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**51.43%**	64.90%	66.67%	**60.10%**	-6.57
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**90.28%**	**91.83%**	**91.63%**	**90.01%**	-1.62
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**83.68%**	**81.40%**	**82.14%**	**80.43%**	-1.71
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**84.53%**	**84.56%**	**84.38%**	**83.17%**	-1.21
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**83.42%**	**82.64%**	**82.39%**	**81.84%**	-0.55
Immunizations for Adolescents—Combination 2	—	22.08%	35.04%	38.44%	3.40
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	67.11%	73.95%	74.45%	67.64%	-6.81

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	49.89%	62.25%	59.61%	65.94%	6.33
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.78%	69.09%	66.67%	69.59%	2.92

Table 3.3—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Molina—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**41.06%**	**58.94%**	**61.56%**	**56.20%**	-5.36
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**89.09%**	**88.98%**	**91.10%**	**90.90%**	-0.20
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**80.68%**	**76.64%**	**79.98%**	**78.68%**	-1.30
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**81.84%**	**82.53%**	**82.50%**	**82.35%**	-0.15
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**79.68%**	**78.83%**	**77.91%**	**79.53%**	1.62
Immunizations for Adolescents—Combination 2	—	18.98%	40.39%	41.61%	1.22
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	70.64%	74.83%	79.81%	72.51%	-7.30

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	53.42%	59.60%	66.67%	71.53%	4.86
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.87%	**61.59%**	71.78%	67.64%	-4.14

Table 3.4—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Molina—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**65.12%**	65.56%	73.72%	68.37%	-5.35
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**90.89%**	**92.95%**	93.29%	93.97%	0.68
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	85.76%	84.93%	85.67%	85.80%	0.13
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.38%	88.60%	88.56%	88.72%	0.16
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.44%	85.93%	85.89%	86.60%	0.71
Immunizations for Adolescents—Combination 2	—	22.74%	36.50%	43.80%	7.30
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	72.41%	76.82%	79.56%	75.67%	-3.89

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	59.16%	64.90%	68.86%	72.99%	4.13
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.39%	69.32%	72.02%	72.51%	0.49

Table 3.5 through Table 3.8 present findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.5 through Table 3.8:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.5—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Molina—Imperial County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.6—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Molina—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	5	20.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	5	20.00%

Table 3.7—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Molina—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	5	20.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	4	25.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	4	0.00%

Table 3.8—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Molina—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Assessment of Improvement Plan—Preventive Screening and Children's Health

The rate for the *Childhood Immunization Status—Combination 3* measure in Sacramento County was below the minimum performance level in reporting year 2018; however, because DHCS had already approved Molina to conduct a PIP to address the MCP's continued performance below the minimum performance level for this measure in Sacramento County, DHCS did not require the MCP to conduct additional IP activities related to this measure. HSAG includes a summary of Molina's progress on the *Childhood Immunization Status—Combination 3* PIP in Section 5 of this report ("Performance Improvement Projects").

The rate remained below the minimum performance level in reporting year 2019 for the *Childhood Immunization Status—Combination 3* measure in Sacramento County.

Preventive Screening and Women's Health

Table 3.9 through Table 3.12 present the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.9 through Table 3.12:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.9—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Molina—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	56.05%	**50.28%**	55.73%	5.45
Cervical Cancer Screening	**41.00%**	49.55%	55.72%	62.53%	6.81
Prenatal and Postpartum Care—Postpartum Care	**54.18%**	**52.54%**	**56.28%**	69.16%	12.88
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**73.58%**	76.27%	**74.46%**	81.06%	6.60

Table 3.10—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Molina—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	59.22%	61.48%	61.47%	-0.01
Cervical Cancer Screening	**50.00%**	50.11%	58.64%	60.34%	1.70
Prenatal and Postpartum Care—Postpartum Care	**46.89%**	**52.67%**	**57.18%**	61.07%	3.89
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**73.33%**	77.78%	78.59%	79.32%	0.73

Table 3.11—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Molina—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	60.24%	63.21%	59.20%	-4.01
Cervical Cancer Screening	55.11%	50.77%	54.99%	**53.28%**	-1.71
Prenatal and Postpartum Care—Postpartum Care	**53.44%**	**50.68%**	63.50%	61.31%	-2.19
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**76.05%**	75.34%	78.83%	78.35%	-0.48

Table 3.12—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Molina—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	63.55%	64.23%	64.99%	0.76
Cervical Cancer Screening	**50.89%**	59.51%	61.56%	62.29%	0.73
Prenatal and Postpartum Care—Postpartum Care	56.44%	69.11%	67.88%	68.86%	0.98
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.78%	83.33%	85.64%	84.91%	-0.73

Table 3.13 through Table 3.16 present findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.13 through Table 3.16:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.13—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Molina—Imperial County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	3	66.67%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	3	3	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	0	N/A

Table 3.14—Preventive Screening and Women's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Molina—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.15—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Molina—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.16—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Molina—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Assessment of Improvement Plans—Preventive Screening and Women's Health

DHCS required Molina to submit IPs for the following measures within the Preventive Screening and Women's Health domain with rates below the minimum performance levels in reporting year 2018:

- *Breast Cancer Screening* in Imperial County
- *Prenatal and Postpartum Care—Postpartum Care* in Imperial and Riverside/San Bernardino counties
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Imperial County

Breast Cancer Screening

Molina conducted two PDSA cycles to test whether targeted beneficiary outreach and education and provider education would result in more beneficiaries obtaining their breast cancer screenings in Imperial County. Molina reported learning that the MCP did not have updated contact information for many of the beneficiaries and that after the third failed call attempt, it was beneficial to contact the provider office to see if the provider had updated beneficiary contact information.

The rate for the *Breast Cancer Screening* measure in Imperial County improved significantly from reporting year 2018 to reporting year 2019, resulting in the rate moving to above the minimum performance level in reporting year 2019.

Postpartum Care

The rates for the *Prenatal and Postpartum Care—Postpartum Care* measure in Imperial and Riverside/San Bernardino counties were below the minimum performance level in reporting year 2018; however, because DHCS had already approved Molina to conduct a PIP to address the MCP's performance below the minimum performance level for this measure, DHCS did not require the MCP to conduct additional IP activities. HSAG includes a summary of Molina's progress on the *Postpartum Care* PIP in Section 5 of this report ("Performance Improvement Projects").

The rates for the *Prenatal and Postpartum Care—Postpartum Care* measure in Imperial and Riverside/San Bernardino counties moved to above the minimum performance level in reporting year 2019.

Prenatal Care

Molina conducted two PDSA cycles to test whether targeted education to all of Molina's contracted obstetricians/gynecologists (OB/GYNs) and primary care provider (PCP) groups in Imperial County would increase the number of pregnancy notification forms submitted by the OB/GYNs and PCPs. The MCP reporting learning that not all provider offices have working fax machines or secure email capabilities. To address this barrier, the MCP began calling the providers and coordinating visits to their offices to pick up paper copies of the forms.

The rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure in Imperial County moved to above the minimum performance level in reporting year 2019.

Care for Chronic Conditions

Table 3.17 through Table 3.20 present the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.17 through Table 3.20:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.17 through Table 3.20. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.17—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Molina—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.47%	91.45%	92.06%	90.13%	-1.93

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	95.00%	90.98%	93.40%	88.39%	-5.01
*Asthma Medication Ratio^*	—	76.24%	69.64%	65.29%	-4.35
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	60.49%	65.27%	64.23%	71.29%	7.06
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	55.19%	57.52%	64.96%	69.83%	4.87
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	**38.19%**	46.46%	46.23%	51.58%	5.35
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	**53.20%**	45.35%	44.53%	37.96%	-6.57
*Comprehensive Diabetes Care—HbA1c Testing^*	**82.12%**	88.50%	84.43%	91.24%	6.81
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	91.17%	91.15%	89.78%	91.97%	2.19
Controlling High Blood Pressure	—	—	—	67.64%	Not Comparable

Table 3.18—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Molina—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.20%	87.58%	86.19%	87.83%	1.64

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	**82.89%**	86.99%	86.04%	86.78%	0.74
*Asthma Medication Ratio^*	—	63.36%	55.88%	**55.00%**	-0.88
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	**51.21%**	59.51%	57.42%	57.66%	0.24
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	48.79%	56.86%	55.96%	54.74%	-1.22
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	41.94%	52.21%	46.72%	50.85%	4.13
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	47.46%	37.17%	42.09%	35.52%	-6.57
*Comprehensive Diabetes Care—HbA1c Testing^*	83.22%	89.82%	88.32%	89.78%	1.46
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	88.52%	92.48%	93.67%	91.48%	-2.19
Controlling High Blood Pressure	—	—	—	59.37%	Not Comparable

Table 3.19—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Molina—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.38%	86.33%	87.65%	**85.01%**	-2.64

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.37%	85.58%	87.38%	**85.97%**	-1.41
*Asthma Medication Ratio^*	—	68.58%	58.06%	**55.57%**	-2.49
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	57.17%	55.43%	66.67%	62.29%	-4.38
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	48.34%	54.77%	55.23%	54.50%	-0.73
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	46.58%	54.99%	55.96%	46.96%	-9.00
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	42.38%	31.93%	34.31%	42.34%	8.03
*Comprehensive Diabetes Care—HbA1c Testing^*	**81.24%**	86.92%	85.64%	**82.00%**	-3.64
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	89.85%	91.35%	88.81%	91.73%	2.92
Controlling High Blood Pressure	—	—	—	53.28%	Not Comparable

Table 3.20—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Molina—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.39%	91.61%	90.40%	90.94%	0.54

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.67%	91.59%	90.38%	91.08%	0.70
*Asthma Medication Ratio^*	—	69.03%	62.55%	61.34%	-1.21
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	**55.85%**	59.91%	70.80%	73.72%	2.92
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	55.19%	59.02%	63.50%	61.56%	-1.94
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	48.57%	56.79%	57.66%	57.42%	-0.24
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	40.62%	35.63%	29.68%	33.33%	3.65
*Comprehensive Diabetes Care—HbA1c Testing^*	87.86%	87.97%	91.73%	90.02%	-1.71
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	91.83%	91.76%	93.19%	91.24%	-1.95
Controlling High Blood Pressure	—	—	—	71.78%	Not Comparable

Table 3.21 through Table 3.24 present findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.21 through Table 3.24:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.21—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Molina—Imperial County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	9	11.11%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Table 3.22—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Molina—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	1	9	11.11%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	9	11.11%

Table 3.23—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Molina—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	4	9	44.44%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	3	9	33.33%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	4	9	44.44%

Table 3.24—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Molina—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Appropriate Treatment and Utilization

Table 3.25 through Table 3.28 present the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.25 through Table 3.28:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent

services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.

- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.25—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Molina—Imperial County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or

reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	54.35	52.35	50.02	46.81	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	238.30	221.57	253.91	293.43	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	34.04%	35.62%	33.33%	**26.89%**	-6.44
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	18.44%	Not Comparable
Use of Imaging Studies for Low Back Pain	**54.62%**	**62.13%**	**53.99%**	**56.25%**	2.26

Table 3.26—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Molina—Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	39.30	37.65	39.51	37.70	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	198.33	197.38	199.70	201.49	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	34.32%	32.89%	32.89%	34.11%	1.22
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	15.08%	Not Comparable
Use of Imaging Studies for Low Back Pain	73.57%	70.35%	71.99%	72.02%	0.03

Table 3.27—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Molina—Sacramento County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	60.04	56.32	56.25	55.53	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	277.80	220.47	242.36	219.83	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	22.32%	35.20%	36.15%	34.58%	-1.57
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	16.46%	Not Comparable
Use of Imaging Studies for Low Back Pain	78.59%	76.04%	75.54%	74.84%	-0.70

Table 3.28—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Molina—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	41.62	40.57	41.35	41.17	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	265.05	266.96	295.72	317.61	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	30.20%	33.18%	37.45%	35.95%	-1.50
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	16.19%	Not Comparable
Use of Imaging Studies for Low Back Pain	**70.74%**	**69.79%**	70.49%	69.60%	-0.89

Table 3.29 through Table 3.32 present findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.29—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Molina—Imperial County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	2	100.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	1	100.00%

Table 3.30—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Molina—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.31—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Molina—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.32—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Molina—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Assessment of Improvement Plan—Appropriate Treatment and Utilization

Based on the rate being below the minimum performance level in reporting year 2018 for the *Use of Imaging Studies for Low Back Pain* measure in Imperial County, DHCS required Molina to submit an IP for the measure. Molina conducted two PDSA cycles to improve the MCP's performance to above the minimum performance level.

Plan-Do-Study-Act Cycle 1

Molina tested whether targeted provider education would result in a decrease in inappropriate imaging prescribing for low back pain. The MCP abandoned the intervention based on learning that working directly with a specific clinic, rather than working with the independent practice association (IPA), did not affect the rates.

Plan-Do-Study-Act Cycle 2

Molina tested whether targeted provider training conducted by the IPA and implementing sanctions would lead to a decrease in inappropriate imaging prescribing for low back pain. The MCP reported learning that it was most productive to work directly with the IPA and for the IPA to communicate with the providers on behalf of Molina.

The rate remained below the minimum performance level in reporting year 2019 for the *Use of Imaging Studies for Low Back Pain* measure in Imperial County.

Performance Measure Findings—All Domains

Table 3.33 through Table 3.36 present a summary of Molina's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.33 through Table 3.36:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high

performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:

- *Asthma Medication Ratio*
- *Breast Cancer Screening*
- *Immunizations for Adolescents—Combination 2*

Table 3.33—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains Molina—Imperial County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	19	5.26%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	4	19	21.05%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	3	4	75.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	15	6.67%

Table 3.34—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Molina—Riverside/San Bernardino Counties

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	18	11.11%

Table 3.35—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Molina—Sacramento County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	5	19	26.32%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	5	19	26.32%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	4	18	22.22%

Table 3.36—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
Molina—San Diego County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	19	0.00%

Improvement Plan Requirements for 2019

Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, DHCS will require Molina to submit IPs or continue IPs for the following measures:

- *Asthma Medication Ratio* in Riverside/San Bernardino and Sacramento counties
- *Childhood Immunization Status—Combination 3* in Riverside/San Bernardino and Sacramento counties
- *Comprehensive Diabetes Care—HbA1c Testing* in Sacramento County

The rates for the following measures in Imperial County were below the minimum performance levels in reporting year 2019; however, DHCS will not require Molina to submit IPs for these measures due to DHCS not requiring MCPs to report rates for these measures to DHCS for reporting year 2020:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Use of Imaging Studies for Low Back Pain*

Additionally, while the rates in Sacramento County were below the minimum performance levels for both *Annual Monitoring for Patients on Persistent Medications* measures in reporting year 2019, DHCS will not require the MCP to submit IPs for these measures due to the small range of variation between the high performance level and minimum performance level thresholds for each measure.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.37 through Table 3.40 present the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.41 through Table 3.44 present the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.45 through Table 3.48 present the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.45 through Table 3.48

Table 3.37—Multi-Year SPD Performance Measure Trend Table
Molina—Imperial County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	114.05	96.92	94.59	89.68	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	567.98	506.57	587.99	652.05	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	96.21%	97.10%	96.55%	91.89%	-4.66
Annual Monitoring for Patients on Persistent Medications—Diuretics	100.00%	97.78%	97.92%	92.77%	-5.15
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA	76.67%	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA	78.18%	84.31%	78.72%	-5.59
*Plan All-Cause Readmissions***	—	—	—	32.35%	Not Comparable

Table 3.38—Multi-Year SPD Performance Measure Trend Table
Molina—Riverside/San Bernardino Counties

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	74.73	74.01	72.60	71.97	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	341.18	352.50	357.88	382.60	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.40%	91.17%	90.35%	91.56%	1.21
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.26%	91.47%	90.83%	90.54%	-0.29
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	81.29%	83.33%	84.75%	82.93%	-1.82
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	84.29%	85.75%	88.09%	88.27%	0.18
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	78.99%	83.33%	84.13%	82.44%	-1.69
*Plan All-Cause Readmissions***	—	—	—	25.46%	Not Comparable

Table 3.39—Multi-Year SPD Performance Measure Trend Table
Molina—Sacramento County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	86.33	92.84	88.97	85.89	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	509.35	420.83	459.41	422.67	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.30%	86.38%	89.08%	86.25%	-2.83
Annual Monitoring for Patients on Persistent Medications—Diuretics	88.41%	87.07%	89.72%	88.47%	-1.25
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.59%	78.85%	83.02%	76.60%	-6.42
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	83.54%	85.00%	84.62%	87.97%	3.35
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	70.97%	71.27%	78.75%	81.61%	2.86
*Plan All-Cause Readmissions***	—	—	—	22.92%	Not Comparable

Table 3.40—Multi-Year SPD Performance Measure Trend Table
Molina—San Diego County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	76.51	74.15	73.91	71.58	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	571.94	591.50	625.08	679.32	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.66%	94.56%	93.21%	92.65%	-0.56
Annual Monitoring for Patients on Persistent Medications—Diuretics	92.84%	95.42%	94.39%	93.45%	-0.94
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	89.50%	90.50%	90.23%	92.82%	2.59
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	88.25%	90.78%	93.08%	92.46%	-0.62
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	86.17%	87.67%	89.60%	90.32%	0.72
*Plan All-Cause Readmissions***	—	—	—	22.67%	Not Comparable

Table 3.41—Multi-Year Non-SPD Performance Measure Trend Table
Molina—Imperial County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	50.01	49.49	24.58	43.97	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	214.32	203.30	121.70	269.67	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.02%	89.66%	90.68%	89.59%	-1.09
Annual Monitoring for Patients on Persistent Medications—Diuretics	92.68%	87.50%	91.15%	86.78%	-4.37
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	83.56%	93.16%	89.80%	94.47%	4.67
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	76.10%	76.39%	74.59%	82.51%	7.92
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	81.56%	76.29%	73.77%	74.45%	0.68
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	79.87%	73.12%	72.48%	73.20%	0.72
*Plan All-Cause Readmissions***	—	—	—	11.93%	Not Comparable

Table 3.42—Multi-Year Non-SPD Performance Measure Trend Table Molina—Riverside/San Bernardino Counties

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	36.92	35.49	37.49	35.62	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	188.78	188.15	190.07	190.50	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.91%	86.45%	84.91%	86.68%	1.77
Annual Monitoring for Patients on Persistent Medications—Diuretics	81.11%	85.48%	84.52%	85.50%	0.98
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	90.23%	91.86%	91.68%	90.04%	-1.64
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.72%	81.37%	82.09%	80.38%	-1.71
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	84.54%	84.53%	84.27%	83.02%	-1.25
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	83.62%	82.62%	82.33%	81.82%	-0.51
*Plan All-Cause Readmissions***	—	—	—	9.41%	Not Comparable

Table 3.43—Multi-Year Non-SPD Performance Measure Trend Table Molina—Sacramento County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	55.21	51.16	40.94	51.36	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	235.22	192.13	168.18	191.98	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.47%	86.29%	87.18%	84.11%	-3.07
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.28%	84.49%	85.48%	83.98%	-1.50
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	89.41%	89.40%	90.76%	90.81%	0.05
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	80.57%	76.59%	79.74%	78.73%	-1.01
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	81.76%	82.44%	82.42%	82.10%	-0.32
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	80.32%	79.29%	77.87%	79.42%	1.55
*Plan All-Cause Readmissions***	—	—	—	10.36%	Not Comparable

Table 3.44—Multi-Year Non-SPD Performance Measure Trend Table
Molina—San Diego County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	39.08	38.43	39.18	39.09	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	242.72	246.33	273.75	292.79	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.13%	90.33%	89.17%	90.18%	1.01
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.78%	89.76%	88.51%	89.92%	1.41
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	90.87%	92.97%	93.26%	93.95%	0.69
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	85.68%	84.83%	85.57%	85.66%	0.09
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.42%	88.54%	88.43%	88.61%	0.18
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.49%	85.87%	85.78%	86.49%	0.71
*Plan All-Cause Readmissions***	—	—	—	13.22%	Not Comparable

Table 3.45—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Molina—Imperial County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	89.68	43.97	Not Tested	46.81
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	652.05	269.67	Not Tested	293.43
Annual Monitoring for Patients on Persistent Medications— ACE Inhibitors or ARBs	91.89%	89.59%	2.30	90.13%
Annual Monitoring for Patients on Persistent Medications— Diuretics	92.77%	86.78%	5.99	88.39%
Children and Adolescents' Access to Primary Care Practitioners— 12–24 Months	NA	94.47%	Not Comparable	94.47%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	NA	82.51%	Not Comparable	82.57%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA	74.45%	Not Comparable	75.03%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	78.72%	73.20%	5.52	73.38%
*Plan All-Cause Readmissions***	32.35%	11.93%	20.42	18.44%

Table 3.46—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Molina—Riverside/San Bernardino Counties

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	71.97	35.62	Not Tested	37.70
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	382.60	190.50	Not Tested	201.49
Annual Monitoring for Patients on Persistent Medications— ACE Inhibitors or ARBs	91.56%	86.68%	4.88	87.83%
Annual Monitoring for Patients on Persistent Medications— Diuretics	90.54%	85.50%	5.04	86.78%
Children and Adolescents' Access to Primary Care Practitioners— 12–24 Months	NA	90.04%	Not Comparable	90.01%
Children and Adolescents' Access to Primary Care Practitioners— 25 Months–6 Years	82.93%	80.38%	2.55	80.43%
Children and Adolescents' Access to Primary Care Practitioners— 7–11 Years	88.27%	83.02%	5.25	83.17%
Children and Adolescents' Access to Primary Care Practitioners— 12–19 Years	82.44%	81.82%	0.62	81.84%
*Plan All-Cause Readmissions***	25.46%	9.41%	16.05	15.08%

Table 3.47—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Molina—Sacramento County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	85.89	51.36	Not Tested	55.53
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	422.67	191.98	Not Tested	219.83
Annual Monitoring for Patients on Persistent Medications— ACE Inhibitors or ARBs	86.25%	84.11%	2.14	85.01%
Annual Monitoring for Patients on Persistent Medications— Diuretics	88.47%	83.98%	4.49	85.97%
Children and Adolescents' Access to Primary Care Practitioners— 12–24 Months	NA	90.81%	Not Comparable	90.90%
Children and Adolescents' Access to Primary Care Practitioners— 25 Months–6 Years	76.60%	78.73%	-2.13	78.68%
Children and Adolescents' Access to Primary Care Practitioners— 7–11 Years	87.97%	82.10%	5.87	82.35%
Children and Adolescents' Access to Primary Care Practitioners— 12–19 Years	81.61%	79.42%	2.19	79.53%
*Plan All-Cause Readmissions***	22.92%	10.36%	12.56	16.46%

Table 3.48—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Molina—San Diego County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	71.58	39.09	Not Tested	41.17
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	679.32	292.79	Not Tested	317.61
Annual Monitoring for Patients on Persistent Medications— ACE Inhibitors or ARBs	92.65%	90.18%	2.47	90.94%
Annual Monitoring for Patients on Persistent Medications— Diuretics	93.45%	89.92%	3.53	91.08%
Children and Adolescents' Access to Primary Care Practitioners— 12–24 Months	NA	93.95%	Not Comparable	93.97%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	92.82%	85.66%	7.16	85.80%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	92.46%	88.61%	3.85	88.72%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	90.32%	86.49%	3.83	86.60%
*Plan All-Cause Readmissions***	22.67%	13.22%	9.45	16.19%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that Molina stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 SPD rate was significantly worse than the reporting year 2018 SPD rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure in Sacramento County.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019:
  - The reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the following measures:
    - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Riverside/San Bernardino counties.
    - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in Imperial County.
    - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in San Diego County.
  - The reporting year 2019 non-SPD rates were significantly worse than the reporting year 2018 non-SPD rates for the following measures:
    - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Sacramento County.
    - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *7–11 Years* in Riverside/San Bernardino counties.

- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
    - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Riverside/San Bernardino and San Diego counties.
    - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Riverside/San Bernardino, Sacramento, and San Diego counties.
    - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *12–19 Years* in San Diego County.
    - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Riverside/San Bernardino and San Diego counties.
  - The reporting year 2019 SPD rates were significantly worse than the reporting year 2019 non-SPD rates for the *Plan All-Cause Readmissions* measure in all four reporting units. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that Molina followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for Molina:

- The rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure was above the high performance level in Imperial County.
- Imperial County had the highest percentage of rates that improved significantly from reporting year 2018 to reporting year 2019 (21 percent), with the rates for the following four measures improving significantly from reporting year 2018 to reporting year 2019:
  - *Breast Cancer Screening*, resulting in the rate moving from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019.
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*.
  - *Comprehensive Diabetes Care—HbA1c Testing*.
  - *Prenatal and Postpartum Care—Postpartum Care*, resulting in the rate moving from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019.
- The rates for the following measures also improved significantly from reporting year 2018 to reporting year 2019:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in Riverside/San Bernardino counties.

  - *Immunizations for Adolescents—Combination 2* in San Diego County.
- Four of the six rates that were below the minimum performance levels in reporting year 2018 (67 percent) moved to above the minimum performance levels in reporting year 2019. These rates represented the following measures:
  - *Breast Cancer Screening* in Imperial County
  - *Prenatal and Postpartum Care—Postpartum Care* in Imperial and Riverside/San Bernardino counties
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Imperial County

Opportunities for Improvement—Performance Measures

Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, HSAG identified the following opportunities for improvement for Molina:

- To improve the MCP's performance, determine the causes for the rates for the following measures being below the minimum performance levels and identify strategies to address the causes:
  - *Asthma Medication Ratio* measure in Riverside/San Bernardino and Sacramento counties. Note that NCQA made specification changes in reporting year 2019 for this measure; therefore, the rates for this measure declining to below the minimum performance level in these reporting units may be due to NCQA's specification changes and may not be related to Molina's performance.
  - *Childhood Immunization Status—Combination 3* measure in Riverside/San Bernardino and Sacramento counties
  - *Comprehensive Diabetes Care—HbA1c Testing* in Sacramento County

  To help improve the rates for the *Childhood Immunization Status—Combination 3* measure, Molina also has the opportunity to build on successes and apply lessons learned from the MCP's *Childhood Immunization Status—Combination 3* PIP.

- Determine the causes for the MCP's performance for the following measures in Sacramento County declining significantly from reporting year 2018 to reporting year 2019 and identify strategies to address the causes:
  - *Breast Cancer Screening*
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

Note that NCQA made specification changes in reporting year 2019 for all measures listed previously under the Opportunities for Improvement—Performance Measures heading; therefore, Molina's reporting year 2019 performance for these measures may be due to NCQA's specification changes and may not be related to the MCP's performance.

In addition to the measures listed previously with rates below the minimum performance levels in reporting year 2019, the rates were below the minimum performance levels in Imperial County for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging Studies for Low Back Pain* measures in reporting year 2019. Also, the rate in Sacramento County declined significantly from reporting year 2018 to reporting year 2019 for the *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* measure. HSAG makes no formal recommendations for these three measures because DHCS will not require MCPs to report the measures to DHCS in reporting year 2020, and DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCP's quality improvement actions related to the measures.

Finally, the rates were below the minimum performance levels in Sacramento County for both *Annual Monitoring for Patients on Persistent Medications* measures in reporting year 2019, and the rate for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure declined significantly from reporting year 2018 to reporting year 2019 in Imperial County. HSAG makes no formal recommendations to the MCP related to the *Annual Monitoring for Patients on Persistent Medications* measures due to the small range of variation between the high performance level and minimum performance level thresholds for each measure.

DHCS and HSAG expect that Molina will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCP will conduct improvement activities, as applicable, related to all measures with rates below the minimum performance levels in reporting year 2019 and with rates that declined significantly from reporting year 2018 to reporting year 2019.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Molina's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Molina report rates for three HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 and Table 4.2 present the rates for each required MLTSSP performance measure for reporting years 2016 through 2019. The reporting year is the year in which the MLTSSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between reporting year 2018 and reporting year 2019. Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of those changes.

Table 4.1—Multi-Year MLTSSP Performance Measure Results
Molina—Riverside/San Bernardino Counties

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's "contribution" to the total yearly membership.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	91.97	94.18	101.91	95.60	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	536.26	565.48	690.91	754.03	Not Tested
Medication Reconciliation Post-Discharge	3.39%	27.54%	29.68%	26.03%	-3.65

Table 4.2—Multi-Year MLTSSP Performance Measure Results
Molina—San Diego County

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	84.73	79.48	83.98	76.01	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	826.99	866.54	1000.41	1084.40	Not Tested
Medication Reconciliation Post-Discharge	3.58%	27.79%	40.63%	41.36%	0.73

Managed Long-Term Services and Supports Plan Performance Measure Findings

The rate for the *Medication Reconciliation Post-Discharge* measure showed no statistically significant change from reporting year 2018 to reporting year 2019 in Riverside/San Bernardino and San Diego counties.

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, Molina conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required Molina to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, Molina selected postpartum care among African-American beneficiaries residing in Riverside and San Bernardino counties as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.1—Molina *Postpartum Care* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of postpartum visits among African-American women residing in Riverside and San Bernardino counties	29.8 %	40.4%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Postpartum Care* Disparity PIP. Upon initial review of the module, HSAG determined that Molina met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Including all required components of the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, Molina incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Postpartum Care* Disparity PIP, HSAG reviewed and provided feedback to Molina on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Molina that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.2 presents a description of the intervention that Molina tested for its *Postpartum Care* Disparity PIP. The table also indicates the key drivers that the intervention addressed.

Table 5.2—Molina *Postpartum Care* Disparity PIP Intervention Testing

Intervention	Key Drivers Addressed
Implement care coordination and outreach efforts based on ethnicity and geographic location information captured from delivery data. Provide education on the importance of the postpartum visit and education about assistance for scheduling a timely postpartum visit.	♦ Socioeconomic factors such as social support, cultural beliefs, and transportation. ♦ Access to childcare in order to seek medical attention needed during the postpartum phase. ♦ A history of previous pregnancies and postpartum care without complications.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Molina to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although Molina completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Molina's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required Molina to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, Molina selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.3—Molina *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of *Childhood Immunization Status—Combination 3* measure at Clinic A[6]	51.9%	69.6%

Intervention Testing

Prior to the intervention testing phase of the *Childhood Immunization Status—Combination 3* PIP, HSAG reviewed and provided feedback to Molina on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Molina that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.4 presents a description of the intervention that Molina tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the key drivers and failure modes that the intervention addressed.

Table 5.4—Molina *Childhood Immunization Status—Combination 3* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Provide gift cards for Clinic A to disseminate directly to beneficiaries once they complete the *Childhood Immunization Status—Combination 3* vaccination series.	♦ Parents lack education or awareness of an immunization schedule. ♦ Parents do not start vaccinating beneficiaries in a timely manner. ♦ Parents misplace beneficiaries' immunization record card.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Molina and conducted technical assistance calls with MCP staff members to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

[6] Clinic name removed for confidentiality.

Although Molina completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Molina's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, Molina submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on Molina's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

7. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

[7] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

8. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with Molina, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

9. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 9.1 provides EQR recommendations from Molina's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 9.1 to preserve the accuracy of Molina's self-reported actions.

Table 9.1—Molina's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP resolves all deficiencies from the August 2017 A&I Medical Audit.	CAPs for all deficiencies identified during the August 2017 A&I Medical Audit were developed and implemented. CAP responses were provided to DHCS. All CAP items were reviewed and accepted by DHCS. On October 19, 2018, DHCS notified Molina that the CAP was closed.
2. For the following measures, assess the causes for the MCP's declining performance or performance below the minimum performance levels and identify strategies to improve performance: a. *Asthma Medication Ratio* in Riverside/San Bernardino, Sacramento, and San Diego counties.	***Asthma Medication Ratio* in Riverside/San Bernardino, Sacramento, and San Diego counties.** ♦ Molina's prescription refill standards for controller medications allowing only 30-day fills contributed to performance below the minimum performance level for the *Asthma Medication Ratio* measure. ♦ A major strategy to improve performance was the change to 90-day fills for controller medications to improve performance.

2017–18 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
b. Both *Annual Monitoring for Patients on Persistent Medications* measures in San Diego County, applying lessons learned from the 2015–17 *Annual Monitoring for Patients on Persistent Medications* PIP, as applicable.	***Annual Monitoring for Patients on Persistent Medications* measures in San Diego County.** ♦ Molina identified providers' lack of awareness of the required annual lab testing for the *Annual Monitoring for Patients on Persistent Medications* measures as a contributing factor for performance below the minimum performance levels for these measures. ♦ The intervention tested during the 2015–17 *Annual Monitoring for Patients on Persistent Medications* PIP was to send a monthly list of members on persistent medications who needed a monitoring lab to the selected high-volume, low-performing clinic in Sacramento County. This list allowed the clinic to perform outreach, schedule appointments, and improve the *Annual Monitoring for Patients on Persistent Medications* rates. ♦ Lessons learned from this PIP included the importance of providing the clinic with timely member lists. This lesson was applied to lists sent to providers in San Diego County to improve performance.
c. *All-Cause Readmissions* in San Diego County	***All-Cause Readmissions* in San Diego County** ♦ Molina identified members' lack of understanding of their post-hospitalization plan and the need for a follow-up appointment after hospital discharge as contributing factors for declining performance for the *All-Cause Readmissions* measure in San Diego County. ♦ Assigning transition of care staff in San Diego to work with appropriate members on their transition plan and follow-up

2017–18 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	appointments after hospital discharge was a major strategy implemented to improve performance in San Diego County.
d. *Breast Cancer Screening* in Imperial County	***Breast Cancer Screening* in Imperial County** ♦ Molina identified providers' lack of awareness of members who were due for breast cancer screening as a contributing factor for performance below the minimum performance level for this measure. ♦ A major strategy to improve performance was sharing member missed services reports with the largest provider groups in Imperial County.
e. *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Imperial County	***Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Imperial County** ♦ Molina identified the low reimbursement rate for prenatal care as a contributing factor for performance below the minimum performance level for this measure. ♦ A major strategy to improve performance was increasing the pay-for-performance incentive amount for timely prenatal care for Imperial County providers. Molina staff met with Imperial County providers monthly to review rates and collaborate on improvement goals.
f. *Prenatal and Postpartum Care—Postpartum Care* in Imperial County	***Prenatal and Postpartum Care—Postpartum Care* in Imperial County** ♦ Molina identified several causes, including members' competing priorities, lack of child care, and lack of transportation as contributing factors for performance below the minimum performance level for this measure. ♦ A major strategy to improve performance was hiring a nurse practitioner to provide

2017–18 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	in-home postpartum care in Imperial County.
3. Continue monitoring adopted and adapted interventions and outcomes to facilitate improvement beyond the life of the 2015–17 *Postpartum Care* and *Annual Monitoring for Patients on Persistent Medications* PIPs.	♦ Molina continues to support the in-home postpartum assessment program in all counties, launching the program in Imperial County in 2018. We have seen continued improvement in our postpartum rates. ♦ Molina continues to provide lists of members on persistent medications who needed a monitoring lab to providers in all counties. This has resulted in improved *Annual Monitoring for Patients on Persistent Medications* rates.
4. Apply lessons learned from the 2015–17 *Postpartum Care* PIP to the MCP's 2017–19 *Postpartum Care* Disparity PIP to address the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure being below the minimum performance level in Riverside/San Bernardino counties for at least four consecutive years. Additionally, use applicable lessons learned in Imperial County to address the rate for the *Prenatal and Postpartum Care—Postpartum Care* measure being below the minimum performance level in Imperial County for at least four consecutive years.	***Prenatal and Postpartum Care—Postpartum Care—Riverside/San Bernardino Counties and Imperial County*** ♦ As a result of lessons learned from the 2015–17 *Postpartum Care* PIP (i.e., the success of the in-home postpartum assessment program), this program was expanded to all counties, which resulted in improved postpartum care rates. ♦ Riverside/San Bernardino counties postpartum care rates for reporting year 2018 (57.18 percent) improved from reporting year 2017 (52.22 percent). In reporting year 2019, the postpartum rate improved by 4 percentage points to 61.07 percent and surpassed the minimum performance level. This was the first year the minimum performance level was surpassed. ♦ Imperial County postpartum care rates for reporting year 2019 improved by 13 percentage points to 69.16 percent from 56.28 percent in reporting year 2018 and surpassed the 50th percentile.

2017–18 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	This was the first year in each county that we surpassed the 25th percentile and the first year in Imperial County that we surpassed the 50th percentile.
5. Conduct the MCP's *Childhood Immunization Status—Combination 3* PIP according to the methodology validated and approved by HSAG to improve the rate for the *Childhood Immunization Status—Combination 3* measure in Sacramento County.	Molina's *Childhood Immunization Status—Combination 3* PIP, focusing on Sacramento County, was conducted as approved by DHCS and HSAG. Progress updates were submitted to DHCS and HSAG in October 2018 and February 2019. The final PIP report was submitted to DHCS and HSAG on August 7, 2019, and is awaiting validation.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Molina's self-reported actions in Table 9.1 and determined that Molina adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. Molina described in detail actions taken during the review period, lessons learned, and steps the MCP plans to take moving forward. HSAG identified the following notable actions taken by the MCP in response to the 2017–18 EQRO recommendations:

- Worked with DHCS to resolve the deficiencies in the Utilization Management, Case Management and Coordination of Care, and Quality Management categories from the August 2017 A&I Medical Audit.
- For measures with rates that declined significantly from reporting year 2017 to reporting year 2018, identified causes for the decline and implemented strategies to address the causes, which may have contributed to the rates for the *Breast Cancer Screening* and two *Prenatal and Postpartum Care* measures in Imperial County improving to above the minimum performance levels in reporting year 2019.
- As a result of lessons learned from the 2015–17 *Postpartum Care* PIP, expanded the in-home postpartum assessment program to all counties, which resulted in improved postpartum care rates in reporting year 2019.

2018–19 Recommendations

Based on the overall assessment of Molina's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to ensure that the MCP fully resolves all findings from the July 30, 2018, through August 3, 2018, Medical and State Supported Services Audits.
- Determine the causes for the rates for the following measures being below the minimum performance levels and identify strategies to address the causes:
  - *Asthma Medication Ratio* measure in Riverside/San Bernardino and Sacramento counties
  - *Childhood Immunization Status—Combination 3* measure in Riverside/San Bernardino and Sacramento counties, building on successes and applying lessons learned from the MCP's *Childhood Immunization Status—Combination 3* PIP
  - *Comprehensive Diabetes Care—HbA1c Testing* in Sacramento County
- Determine the causes for the MCP's performance for the following measures in Sacramento County declining significantly from reporting year 2018 to reporting year 2019 and identify strategies to address the causes:
  - *Breast Cancer Screening*
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

In the next annual review, HSAG will evaluate continued successes of Molina as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix AA:
Performance Evaluation Report
Partnership HealthPlan of California
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Partnership HealthPlan of California ("Partnership" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in Partnership's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

Partnership is a full-scope MCP delivering services to beneficiaries in the County Organized Health System model.

Partnership became operational to provide MCMC services in Solano County effective May 1994, in Napa County in March 1998, in Yolo County in March 2001, in Sonoma County in October 2009, and in Marin and Mendocino counties in July 2011. As part of the expansion authority under Section 1115 of the Social Security Act, MCMC expanded into several rural northern counties of California in 2013. Under the expansion, Partnership contracted with DHCS to provide MCMC services in Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties beginning November 1, 2013.

Table 1.1 shows the number of beneficiaries for Partnership for each county and the MCP's total number of beneficiaries as of June 2019.[1]

Table 1.1—Partnership Enrollment as of June 2019

County	Enrollment as of June 2019
Del Norte	11,130
Humboldt	51,901
Lake	29,734
Lassen	7,006
Marin	37,189
Mendocino	37,277
Modoc	3,160
Napa	27,540
Shasta	58,519
Siskiyou	17,025
Solano	105,627
Sonoma	104,129
Trinity	4,192
Yolo	50,694
	545,123

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

DHCS allows Partnership to combine data into four regions for reporting purposes. Partnership's regions are as follows:

- **Northeast**—Lassen, Modoc, Shasta, Siskiyou, and Trinity counties
- **Northwest**—Del Norte and Humboldt counties
- **Southeast**—Napa, Solano, and Yolo counties
- **Southwest**—Lake, Marin, Mendocino, and Sonoma counties

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent review conducted for Partnership. The description of the review may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical Audit of Partnership. A&I conducted the audit from February 4, 2019, through February 8, 2019. Note that DHCS sent Partnership its final response to the MCP's corrective action plan (CAP) on July 17, 2019, which is outside the review period for this report; however, HSAG includes the information because it reflects full resolution of all findings from the February 2019 Medical Audit.

Table 2.1—DHCS A&I Medical Audit of Partnership
Audit Review Period: January 1, 2018, through December 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	No	No findings.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	No	No findings.
Administrative and Organizational Capacity	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in five of the six categories assessed during the February 2019 Medical Audit of Partnership. Additionally, Partnership's CAP response regarding the finding in the Member's Rights category resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

Partnership has no outstanding findings from the February 2019 A&I Medical Audit; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for Partnership HealthPlan of California* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that Partnership followed the appropriate specifications to produce valid rates; however, the auditor identified the following opportunities for improvement:

- The MCP did not track rejected claims for capitated services. Since the volume of encounters received from capitated providers is significant, it is important that Partnership institute monitoring of these rejected data to ensure that complete data are received in time for performance measure reporting.
- Partnership has the opportunity to increase oversight of the data received from its health plan subcontractor, Kaiser, to ensure that Kaiser has included all appropriate fields in the data files for performance measure data calculation. While the measures affected for HEDIS 2019 were the *Depression Screening and Follow-Up for Adolescents and Adults* measures, which DHCS will not require MCPs to report for reporting year 2020, such data integrity issues could affect other measure rates. Partnership should conduct ongoing data checks to ensure that corrective actions can be instituted prior to sample selection for hybrid measures as well as rate calculation.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.36 for Partnership's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.36:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.32 present the performance measure results and findings by domain, and Table 3.33

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

through Table 3.36 present the reporting year 2019 performance measure findings for the domains combined.

- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.
- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 through Table 3.4 present the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1 through Table 3.4:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions

[4] Quality Compass® is a registered trademark of NCQA.

due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

Table 3.1—Preventive Screening and Children's Health Domain Multi-Year Performance Measure Results Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**56.61%**	**56.54%**	**58.02%**	**52.55%**	-5.47

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**91.69%**	**91.93%**	**93.13%**	**91.21%**	-1.92
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**81.83%**	**80.44%**	**82.20%**	**80.91%**	-1.29
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**80.72%**	**80.69%**	**82.03%**	**81.87%**	-0.16
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**83.31%**	**81.74%**	**82.44%**	**82.14%**	-0.30
Immunizations for Adolescents—Combination 2	—	11.19%	**14.60%**	**17.52%**	2.92
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	58.64%	58.88%	62.53%	63.50%	0.97

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	51.58%	51.82%	57.91%	61.80%	3.89
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**63.66%**	65.10%	67.29%	**62.02%**	-5.27

Table 3.2—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Partnership—Northwest (Del Norte and Humboldt Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	**56.54%**	**60.00%**	**55.44%**	**53.53%**	-1.91
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	95.06%	95.33%	94.58%	95.07%	0.49
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	85.80%	86.14%	**84.85%**	**83.29%**	-1.56
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**86.57%**	**84.48%**	**84.55%**	**84.77%**	0.22
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**87.00%**	**85.83%**	**85.17%**	**84.33%**	-0.84
Immunizations for Adolescents—Combination 2	—	17.52%	27.98%	**25.55%**	-2.43
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	57.18%	63.41%	68.40%	64.06%	-4.34

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	56.20%	59.51%	65.68%	64.58%	-1.10
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**60.05%**	71.65%	**63.45%**	**63.26%**	-0.19

Table 3.3—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	71.67%	74.56%	73.21%	73.48%	0.27
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**94.07%**	94.32%	94.54%	94.35%	-0.19
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**85.06%**	85.05%	86.51%	86.27%	-0.24
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	**86.22%**	**86.83%**	**87.34%**	**87.44%**	0.10
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**84.94%**	**85.31%**	86.25%	87.14%	0.89
Immunizations for Adolescents—Combination 2	—	30.17%	45.50%	46.96%	1.46
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	81.40%	80.18%	77.91%	76.90%	-1.01

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	76.28%	75.30%	73.73%	72.51%	-1.22
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.64%	78.04%	75.00%	68.37%	-6.63

Table 3.4—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	66.77%	66.85%	**64.42%**	68.86%	4.44
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	95.62%	95.15%	95.19%	95.97%	0.78
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.55%	87.74%	87.85%	88.49%	0.64
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.30%	88.34%	88.96%	89.29%	0.33
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.67%	87.92%	88.66%	88.59%	-0.07
Immunizations for Adolescents—Combination 2	—	28.22%	36.98%	39.42%	2.44
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	72.99%	76.56%	77.40%	81.92%	4.52

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	63.75%	72.07%	70.90%	76.84%	5.94
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.13%	75.61%	84.03%	74.24%	-9.79

Table 3.5 through Table 3.8 present findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.5 through Table 3.8:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.5—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	2	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	5	60.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	4	25.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	3	33.33%

Table 3.6—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Partnership—Northwest (Del Norte and Humboldt Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	2	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	3	5	60.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	4	25.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	3	33.33%

Table 3.7—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Partnership—Southeast (Napa, Solano, and Yolo Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	5	20.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Table 3.8—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	5	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	4	0.00%

Assessment of Corrective Action Plan—Preventive Screening and Children's Health

Based on reporting year 2018 performance measure results, DHCS required Partnership to conduct IPs for the following measures within the Preventive Screening and Children's Health domain as part of the MCP's CAP:

- *Childhood Immunization Status—Combination 3* in the Northeast, Northwest, and Southwest regions
- *Immunizations for Adolescents—Combination 2* in the Northeast Region
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in the Northwest Region

Childhood Immunizations

DHCS previously approved Partnership to conduct a PIP to address the MCP's continued performance below the minimum performance level for the *Childhood Immunization Status—Combination 3* measure in the Northeast and Northwest regions; therefore, DHCS did not require the MCP to conduct additional IP activities related to this measure in the Northeast, Northwest, and Southwest regions. HSAG includes a summary of Partnership's progress on the *Childhood Immunization Status—Combination 3* PIP in Section 4 of this report ("Performance Improvement Projects").

Immunizations for Adolescents

Based on reporting year 2018 performance measure results, DHCS required Partnership to submit an IP for the *Immunizations for Adolescents—Combination 2* measure in the Northeast Region. Partnership conducted two PDSA cycles to improve the MCP's performance for this measure.

For both PDSA cycles, Partnership tested whether holding immunization clinic days early in the year, prior to the back-to-school time frame, along with using gap-in-care lists and conducting beneficiary outreach that included beneficiary incentives, would improve the *Immunizations for Adolescents—Combination 2* measure rate. The MCP initially experienced unexpected delays in receiving the California Vaccine for Children (VFC) Program supplemental order and addressed this issue with the VFC Program to avoid future delays.

The *Immunizations for Adolescents—Combination 2* measure rate remained below the minimum performance level in the Northeast Region in reporting year 2019.

Well-Child Visits

Based on reporting year 2018 performance measure results, DHCS required Partnership to submit an IP for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in the Northwest Region. Partnership conducted two PDSA cycles to improve the MCP's performance for this measure.

For both PDSA cycles, Partnership tested whether offering a "Birthday Club" beneficiary incentive would improve the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate in the Northwest Region and increase beneficiary awareness of the importance of well-child visits. Partnership reported learning that the "Birthday Club" model of linking the well-child exam to the child's birthday helps to mitigate access issues by promoting the spacing of exams evenly throughout the year. Additionally, this approach enhances rapport between the provider and beneficiaries through the distribution of the incentive.

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate remained below the minimum performance level in the Northwest Region in reporting year 2019.

Preventive Screening and Women's Health

Table 3.9 through Table 3.12 present the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.9 through Table 3.12:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.9—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**50.67%**	**51.53%**	53.32%	1.79
Cervical Cancer Screening	**42.09%**	52.07%	55.61%	55.28%	-0.33
Prenatal and Postpartum Care—Postpartum Care	**49.27%**	61.56%	60.71%	59.61%	-1.10
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**72.44%**	81.27%	79.59%	84.43%	4.84

Table 3.10—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Partnership—Northwest (Del Norte and Humboldt Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**46.04%**	**47.31%**	**47.75%**	0.44
Cervical Cancer Screening	**44.04%**	49.15%	54.99%	**49.88%**	-5.11
Prenatal and Postpartum Care—Postpartum Care	59.37%	65.08%	60.11%	69.59%	9.48
Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.54%	84.42%	80.32%	87.35%	7.03

Table 3.11—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	57.20%	56.96%	60.33%	3.37
Cervical Cancer Screening	60.10%	67.09%	66.39%	65.77%	-0.62
Prenatal and Postpartum Care—Postpartum Care	66.38%	72.51%	67.76%	76.16%	8.40
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.46%	85.44%	83.88%	86.13%	2.25

Table 3.12—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	**52.06%**	52.85%	56.30%	3.45
Cervical Cancer Screening	57.78%	59.06%	57.79%	71.46%	13.67
Prenatal and Postpartum Care—Postpartum Care	68.33%	69.17%	73.73%	79.57%	5.84
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.94%	89.44%	87.01%	91.16%	4.15

Table 3.13 through Table 3.16 present findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.13 through Table 3.16:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.13—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.14—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Partnership—Northwest (Del Norte and Humboldt Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	3	66.67%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	1	3	33.33%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.15—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Partnership—Southeast (Napa, Solano, and Yolo Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	3	33.33%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	3	66.67%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Table 3.16—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	3	66.67%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Assessment of Corrective Action Plan—Preventive Screening and Women's Health

Based on reporting year 2018 performance measure results, DHCS required Partnership to conduct an IP for the *Breast Cancer Screening* measure in the Northeast and Northwest regions as part of the MCP's CAP.

Partnership conducted two PDSA cycles to test whether using the imaging provider's physician portal would simplify the referral process for beneficiaries in the Northeast Region. The imaging provider's beneficiary outreach process was used to schedule the mammograms. Based on lessons learned, Partnership made adjustments to the intervention and reported exceeding its goal for the second PDSA cycle.

The *Breast Cancer Screening* measure rate improved to above the minimum performance level in the Northeast Region in reporting year 2019, and the rate for this measure remained below the minimum performance level in the Northwest Region in reporting year 2019.

Care for Chronic Conditions

Table 3.17 through Table 3.20 present the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.17 through Table 3.20:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures

- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.17 through Table 3.20. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.17—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**81.68%**	**82.40%**	**83.80%**	**85.01%**	1.21
Annual Monitoring for Patients on Persistent Medications—Diuretics	**83.40%**	**84.77%**	**84.51%**	87.60%	3.09
*Asthma Medication Ratio^*	—	**50.89%**	**52.02%**	**50.90%**	-1.12
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	64.23%	70.32%	68.37%	75.18%	6.81
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**43.07%**	49.64%	55.72%	65.94%	10.22
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	44.04%	52.07%	50.36%	57.91%	7.55
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	46.96%	38.69%	38.69%	32.12%	-6.57
*Comprehensive Diabetes Care—HbA1c Testing^*	86.86%	85.89%	87.10%	90.51%	3.41

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	87.35%	89.78%	90.02%	88.56%	-1.46
Controlling High Blood Pressure	—	—	—	65.94%	Not Comparable

Table 3.18—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Partnership—Northwest (Del Norte and Humboldt Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**78.82%**	**85.55%**	**84.45%**	**83.95%**	-0.50
Annual Monitoring for Patients on Persistent Medications—Diuretics	**80.46%**	86.06%	86.10%	**84.36%**	-1.74
*Asthma Medication Ratio^*	—	**50.39%**	**50.44%**	**50.20%**	-0.24
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	60.58%	63.26%	61.80%	67.40%	5.60
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	**42.82%**	47.93%	47.93%	**45.26%**	-2.67
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	48.42%	51.09%	52.55%	53.53%	0.98
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	39.66%	40.15%	34.06%	31.14%	-2.92
*Comprehensive Diabetes Care—HbA1c Testing^*	83.70%	91.24%	87.59%	89.78%	2.19

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	85.16%	**87.83%**	**87.10%**	**88.08%**	0.98
Controlling High Blood Pressure	—	—	—	56.20%	Not Comparable

Table 3.19—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.39%	87.11%	89.30%	90.88%	1.58
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.33%	86.20%	88.77%	90.41%	1.64
*Asthma Medication Ratio^*	—	66.67%	65.41%	64.65%	-0.76
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	63.66%	63.81%	68.95%	67.00%	-1.95
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	60.98%	59.41%	62.59%	63.03%	0.44
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	54.15%	54.03%	57.21%	54.34%	-2.87
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	35.61%	34.72%	31.78%	30.77%	-1.01
*Comprehensive Diabetes Care—HbA1c Testing^*	85.12%	84.35%	93.15%	91.81%	-1.34

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	87.56%	90.46%	93.40%	94.79%	1.39
Controlling High Blood Pressure	—	—	—	63.50%	Not Comparable

Table 3.20—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	**83.40%**	**84.92%**	86.68%	88.88%	2.20
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.03%	**84.85%**	87.01%	89.82%	2.81
*Asthma Medication Ratio^*	—	59.74%	57.37%	**55.00%**	-2.37
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	71.29%	68.61%	69.34%	72.02%	2.68
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	54.01%	57.42%	60.34%	70.80%	10.46
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	48.91%	51.34%	52.07%	54.74%	2.67
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	40.15%	37.71%	37.96%	33.82%	-4.14
*Comprehensive Diabetes Care—HbA1c Testing^*	87.10%	89.29%	88.81%	90.02%	1.21

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	86.62%	**84.67%**	**86.13%**	**87.10%**	0.97
Controlling High Blood Pressure	—	—	—	59.85%	Not Comparable

Table 3.21 through Table 3.24 present findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.21 through Table 3.24:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.21—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	5	9	55.56%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	3	33.33%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	9	22.22%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	8	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	6	0.00%

Table 3.22—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Partnership—Northwest (Del Norte and Humboldt Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	3	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	5	9	55.56%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	2	8	25.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	2	6	33.33%

Table 3.23—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Partnership—Southeast (Napa, Solano, and Yolo Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	9	11.11%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Table 3.24—Care for Chronic Conditions Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	9	11.11%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	3	9	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	1	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	9	22.22%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	8	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	8	12.50%

Assessment of Corrective Acton Plan—Care for Chronic Conditions

Based on reporting year 2018 performance measure results, DHCS required Partnership to conduct IPs for the following measures within the Care for Chronic Conditions domain as part of the MCP's CAP:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in the Northeast and Northwest regions
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in the Northeast Region

- *Asthma Medication Ratio* in the Northeast and Northwest regions
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in the Northwest and Southwest regions

Annual Monitoring for Patients on Persistent Medications

Partnership conducted two PDSA cycles to test whether coupling beneficiary outreach calls and clinical education with a mailer that included a letter and lab slip from the PCP would result in more beneficiaries having their labs completed. Partnership reported learning that sending the mailer in advance of the outreach calls resulted in more productive phone conversations with the outreach nurse.

The rate for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure in the Northeast Region improved to above the minimum performance level in reporting year 2019.

The rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure in the Northeast and Northwest regions remained below the minimum performance level in reporting year 2019.

Asthma Medication Ratio

Partnership conducted two PDSA cycles to test whether point-of-sale (POS) messaging designed to trigger face-to-face beneficiary engagement and education by pharmacy staff members would result in beneficiaries using asthma controller medications.

Although Partnership reported that the results exceeded the intervention goals (see Table 8.1), the *Asthma Medication Ratio* measure rates in the Northeast and Northwest regions remained below the minimum performance level in reporting year 2019.

Comprehensive Diabetes Care—Medical Attention for Nephropathy

DHCS previously approved Partnership to conduct a PIP to address the MCP's performance below the minimum performance level for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure in the Northwest and Southwest regions; therefore, DHCS did not require the MCP to conduct additional IP activities related to this measure. HSAG includes a summary of Partnership's progress on the *Diabetes Nephropathy Screening* Disparity PIP in Section 4 of this report ("Performance Improvement Projects").

The rates for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure in the Northwest and Southwest regions remained below the minimum performance level in reporting year 2019.

Appropriate Treatment and Utilization

Table 3.25 through Table 3.28 present the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.25 through Table 3.28:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.25—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	73.36	58.66	57.51	55.48	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	239.00	227.19	239.56	237.71	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	27.22%	36.13%	35.93%	36.68%	0.75
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	13.66%	Not Comparable
Use of Imaging Studies for Low Back Pain	81.63%	76.30%	75.67%	76.34%	0.67

Table 3.26—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Partnership—Northwest (Del Norte and Humboldt Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	57.05	46.87	46.15	42.35	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	228.31	214.55	210.39	210.49	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	34.43%	32.51%	34.87%	30.29%	-4.58
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	10.75%	Not Comparable
Use of Imaging Studies for Low Back Pain	85.71%	81.16%	80.33%	81.98%	1.65

Table 3.27—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	59.17	50.03	49.36	49.33	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	281.18	235.96	242.27	258.84	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	34.81%	42.55%	41.20%	46.81%	5.61
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	14.17%	Not Comparable
Use of Imaging Studies for Low Back Pain	86.27%	83.03%	82.29%	82.62%	0.33

Table 3.28—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP’s measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule’s de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	52.36	45.42	45.12	45.91	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	302.06	253.48	260.68	272.05	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	41.15%	44.06%	44.46%	46.89%	2.43
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	S	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	NA	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	13.30%	Not Comparable
Use of Imaging Studies for Low Back Pain	87.86%	83.84%	82.95%	83.25%	0.30

Table 3.29 through Table 3.32 present findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting

year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.29—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.30—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Partnership—Northwest (Del Norte and Humboldt Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	2	50.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.31—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Partnership—Southeast (Napa, Solano, and Yolo Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	2	100.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	2	100.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	2	50.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Table 3.32—Appropriate Treatment and Utilization Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	2	100.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	2	100.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.33 through Table 3.36 present a summary of Partnership's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.33 through Table 3.36:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.33—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	19	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	5	19	26.32%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	2	6	33.33%
Reporting Year 2019 Rates Below Minimum Performance Levels	5	19	26.32%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	2	19	10.53%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	13	7.69%

Table 3.34—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains Partnership—Northwest (Del Norte and Humboldt Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	19	5.26%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	6	0.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	9	19	47.37%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	3	19	15.79%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	3	16	18.75%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	3	13	23.08%

Table 3.35—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains Partnership—Southeast (Napa, Solano, and Yolo Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	5	19	26.32%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	5	19	26.32%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	19	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	19	0.00%

Table 3.36—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	5	19	26.32%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	16	12.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	4	19	21.05%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	2	50.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	2	19	10.53%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	1	16	6.25%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	1	17	5.88%

Corrective Action Plan Requirements for 2019

Partnership's CAP will continue based on the MCP not achieving the CAP goals in reporting year 2019. Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, the following measures are included in Partnership's CAP:

- *Asthma Medication Ratio* in the Northeast, Northwest, and Southwest regions
- *Breast Cancer Screening* in the Northwest Region
- *Childhood Immunization Status—Combination 3* in the Northeast and Northwest regions
- *Immunizations for Adolescents—Combination 2* in the Northeast and Northwest regions
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in the Northeast and Northwest regions

The rates for the following measures were below the minimum performance levels in reporting year 2019; however, DHCS will not include these measures in Partnership's CAP due to DHCS not requiring MCPs to report rates for these measures for reporting year 2020:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in the Northwest Region
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in the Northwest and Southwest regions

The rates for the following measures also were below the minimum performance levels in reporting year 2019:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in the Northeast and Northwest regions
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in the Northwest Region

DHCS will not include the *Annual Monitoring for Patients on Persistent Medications* measures in Partnership's CAP due to the small range of variation between the high performance level and minimum performance level thresholds for each measure.

Seniors and Persons with Disabilities Performance Measure Results

Table 3.37 through Table 3.40 present the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.41 through Table 3.44 present the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.45 through Table 3.48 present the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.37—Multi-Year SPD Performance Measure Trend Table Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.45 through Table 3.48.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	127.31	97.28	94.48	91.89	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	431.95	413.11	428.15	425.58	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.51%	87.04%	87.01%	88.32%	1.31
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.57%	89.89%	88.35%	90.84%	2.49
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.20%	87.05%	86.29%	87.20%	0.91
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	87.50%	87.50%	88.36%	91.74%	3.38

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.84%	83.76%	85.45%	85.13%	-0.32
*Plan All-Cause Readmissions***	—	—	—	19.14%	Not Comparable

Table 3.38—Multi-Year SPD Performance Measure Trend Table
Partnership—Northwest (Del Norte and Humboldt Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	106.26	86.42	86.57	82.06	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	405.91	383.59	365.23	381.47	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	83.62%	90.38%	88.52%	87.70%	-0.82
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.64%	91.19%	90.43%	89.37%	-1.06
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	97.25%	92.25%	89.43%	87.29%	-2.14
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	93.02%	91.52%	90.51%	90.65%	0.14

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	89.67%	88.93%	89.39%	91.60%	2.21
*Plan All-Cause Readmissions***	—	—	—	14.24%	Not Comparable

Table 3.39—Multi-Year SPD Performance Measure Trend Table Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	104.12	88.36	90.16	92.05	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	488.22	425.85	433.31	459.79	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.74%	90.21%	90.89%	93.15%	2.26
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.42%	90.69%	90.88%	92.83%	1.95
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	93.55%	NA	87.88%	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	86.02%	84.52%	91.29%	88.98%	-2.31
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.19%	89.80%	90.99%	91.27%	0.28

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	81.49%	83.48%	86.02%	87.33%	1.31
*Plan All-Cause Readmissions***	—	—	—	20.23%	Not Comparable

Table 3.40—Multi-Year SPD Performance Measure Trend Table Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	98.56	90.11	85.96	85.41	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	553.37	484.79	489.42	490.84	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.28%	88.40%	90.40%	91.02%	0.62
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.81%	87.62%	90.12%	92.17%	2.05
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	88.15%	90.45%	90.40%	92.76%	2.36
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.49%	89.74%	94.38%	95.78%	1.40

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.67%	88.30%	91.27%	93.64%	2.37
*Plan All-Cause Readmissions***	—	—	—	17.12%	Not Comparable

Table 3.41—Multi-Year Non-SPD Performance Measure Trend Table
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	66.30	54.02	53.17	51.30	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	213.75	204.85	217.40	216.15	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	78.33%	79.41%	81.73%	82.97%	1.24
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.00%	81.31%	81.91%	85.44%	3.53
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	91.63%	91.84%	93.05%	91.22%	-1.83
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	81.68%	80.27%	82.10%	80.78%	-1.32
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	80.43%	80.43%	81.80%	81.53%	-0.27

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	83.21%	81.61%	82.27%	82.00%	-0.27
*Plan All-Cause Readmissions***	—	—	—	9.03%	Not Comparable

Table 3.42—Multi-Year Non-SPD Performance Measure Trend Table Partnership—Northwest (Del Norte and Humboldt Counties)

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	51.30	42.89	42.43	38.78	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	207.55	197.53	196.14	195.10	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	75.62%	83.02%	82.58%	82.31%	-0.27
Annual Monitoring for Patients on Persistent Medications—Diuretics	77.21%	83.10%	83.82%	81.79%	-2.03
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	95.04%	95.30%	94.55%	95.15%	0.60
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	85.56%	85.99%	84.74%	83.19%	-1.55
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.27%	84.23%	84.35%	84.59%	0.24

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	86.82%	85.67%	84.97%	84.04%	-0.93
*Plan All-Cause Readmissions***	—	—	—	8.57%	Not Comparable

Table 3.43—Multi-Year Non-SPD Performance Measure Trend Table Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	54.90	46.75	46.07	45.77	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	261.52	219.72	226.85	242.06	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.13%	85.68%	88.58%	89.89%	1.31
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.98%	83.96%	87.68%	89.17%	1.49
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	94.08%	94.34%	94.60%	94.35%	-0.25
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	85.03%	85.06%	86.40%	86.21%	-0.19
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.22%	86.70%	87.21%	87.31%	0.10

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	85.18%	85.41%	86.27%	87.13%	0.86
*Plan All-Cause Readmissions***	—	—	—	10.45%	Not Comparable

Table 3.44—Multi-Year Non-SPD Performance Measure Trend Table Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	48.71	42.23	42.45	43.30	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	282.20	237.01	245.73	257.54	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.65%	83.58%	85.32%	88.09%	2.77
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.60%	83.60%	85.76%	88.85%	3.09
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	95.67%	95.12%	95.16%	96.01%	0.85
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.54%	87.69%	87.81%	88.43%	0.62
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.24%	88.30%	88.83%	89.15%	0.32

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	88.71%	87.91%	88.57%	88.45%	-0.12
*Plan All-Cause Readmissions***	—	—	—	11.59%	Not Comparable

Table 3.45—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	91.89	51.30	Not Tested	55.48
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	425.58	216.15	Not Tested	237.71
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.32%	82.97%	5.35	85.01%
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.84%	85.44%	5.40	87.60%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	91.22%	Not Comparable	91.21%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.20%	80.78%	6.42	80.91%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.74%	81.53%	10.21	81.87%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	85.13%	82.00%	3.13	82.14%
*Plan All-Cause Readmissions***	19.14%	9.03%	10.11	13.66%

Table 3.46—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Partnership—Northwest (Del Norte and Humboldt Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	82.06	38.78	Not Tested	42.35
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	381.47	195.10	Not Tested	210.49
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.70%	82.31%	5.39	83.95%
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.37%	81.79%	7.58	84.36%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	95.15%	Not Comparable	95.07%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	87.29%	83.19%	4.10	83.29%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	90.65%	84.59%	6.06	84.77%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	91.60%	84.04%	7.56	84.33%
*Plan All-Cause Readmissions***	14.24%	8.57%	5.67	10.75%

Table 3.47—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	92.05	45.77	Not Tested	49.33
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	459.79	242.06	Not Tested	258.84
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	93.15%	89.89%	3.26	90.88%
Annual Monitoring for Patients on Persistent Medications—Diuretics	92.83%	89.17%	3.66	90.41%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	94.35%	Not Comparable	94.35%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	88.98%	86.21%	2.77	86.27%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	91.27%	87.31%	3.96	87.44%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	87.33%	87.13%	0.20	87.14%
*Plan All-Cause Readmissions***	20.23%	10.45%	9.78	14.17%

Table 3.48—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	85.41	43.30	Not Tested	45.91
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	490.84	257.54	Not Tested	272.05
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	91.02%	88.09%	2.93	88.88%
Annual Monitoring for Patients on Persistent Medications—Diuretics	92.17%	88.85%	3.32	89.82%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	96.01%	Not Comparable	95.97%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	92.76%	88.43%	4.33	88.49%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	95.78%	89.15%	6.63	89.29%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	93.64%	88.45%	5.19	88.59%
*Plan All-Cause Readmissions***	17.12%	11.59%	5.53	13.30%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that Partnership stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 SPD rate was better than the reporting year 2018 SPD rate for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure in the Southeast Region.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019:
  - The reporting year 2019 non-SPD rates were significantly better than the reporting year 2018 non-SPD rates for the following measures:
    - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in the Southeast and Southwest regions.
    - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in the Northeast and Southwest regions
    - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in the Southeast Region
  - The reporting year 2019 non-SPD rates were significantly worse than the reporting year 2018 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* measure in the Northeast and Northwest regions.
- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for the following measures:
    - Both *Annual Monitoring for Patients on Persistent Medications* measures in all four regions
    - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* in the Northeast and Southwest regions
    - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in the Northeast, Southeast, and Southwest regions
    - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in the Northwest and Southwest regions
  - The reporting year 2019 SPD rates were significantly worse than the reporting year 2019 non-SPD rates for the *Plan All-Cause Readmissions* measure in all four regions. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that Partnership followed the appropriate specifications to produce valid rates.

HSAG identified the following notable reporting year 2019 performance measure results for Partnership:

- Across all domains and regions, 11 of 76 rates (14 percent) were above the high performance levels.
  - The rates for the following measures were above the high performance levels for the last three or more consecutive years in the Southeast and Southwest regions:
    - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
    - *Use of Imaging Studies for Low Back Pain*
  - The Southeast and Southwest regions each had five of 19 measures (26 percent) with rates above the high performance levels.
- Across all domains and regions, 16 of 76 rates for which HSAG made comparisons between reporting year 2018 and reporting year 2019 (21 percent) improved significantly from reporting year 2018 to reporting year 2019.
- Three of the 14 rates that were below the minimum performance levels in reporting year 2018 (21 percent) improved to above the minimum performance levels in reporting year 2019. The rates were for the following measures:
  - *Annual Monitoring for Patients on Persistent Medications—Diuretics* in the Northeast Region
  - *Breast Cancer Screening* in the Northeast Region
  - *Childhood Immunization Status—Combination 3* in the Southwest Region

Opportunities for Improvement—Performance Measures

HSAG's auditor determined that Partnership has the opportunity to improve the MCP's oversight processes related to performance measure rate calculation and reporting. Specifically, Partnership has the opportunity to:

- Institute monitoring of rejected claim volume for capitated services to ensure that complete data are received in time for performance measure reporting.
- Increase oversight of the data received from Kaiser to ensure that Kaiser has included all appropriate fields in the data files for performance measure data calculation and conduct ongoing data checks to ensure that corrective actions can be instituted prior to sample selection for hybrid measures as well as rate calculation.

Based on reporting year 2019 performance measure results and DHCS' decisions regarding reporting year 2020 performance measure requirements, Partnership has opportunities to

determine whether the MCP needs to modify or expand its current strategies to improve the MCP's performance to above the minimum performance levels for the following measures:

- *Asthma Medication Ratio* in the Northeast, Northwest, and Southwest regions
- *Breast Cancer Screening* in the Northwest Region
- *Childhood Immunization Status—Combination 3* in the Northeast and Northwest regions
- *Immunizations for Adolescents—Combination 2* in the Northeast and Northwest regions
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in the Northeast and Northwest regions

In addition to the measures listed previously with rates below the minimum performance levels in reporting year 2019, the rates for the following two measures were below the minimum performance levels in reporting year 2019:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* in the Northwest Region
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in the Northwest and Southwest regions

Note that while Partnership has opportunities for improvement related to these two measures, HSAG makes no formal recommendations for these measures because DHCS will not require MCPs to report the measures in reporting year 2020, and DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCP's quality improvement actions related to the measures.

Additionally, the rates for the following two measures were below the minimum performance levels in reporting year 2019:

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in the Northeast and Northwest regions
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in the Northwest Region

While Partnership has opportunities for improvement related to these two measures, HSAG makes no formal recommendations to the MCP due to the small range of variation between the high performance level and minimum performance level thresholds for each measure.

DHCS and HSAG expect that Partnership will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCP will conduct improvement activities, as applicable, related to the *Annual Monitoring for Patients on Persistent Medications*, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, and *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, Partnership conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required Partnership to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, Partnership identified diabetes nephropathy screening among beneficiaries residing in the Southwest Region as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—Partnership *Diabetes Nephropathy Screening* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of nephropathy screening among beneficiaries diagnosed with diabetes, ages 18 to 75, assigned to Health Center A.[6]	73.00%	88.32%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Diabetes Nephropathy Screening* Disparity PIP. Upon initial review of the module, HSAG determined that Partnership met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Including all required components of the FMEA table.
- Describing the priority-ranking process.
- Listing the appropriate potential interventions based on the ranked failure modes.

[6] Health center name removed for confidentiality.

After receiving technical assistance from HSAG, Partnership incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Diabetes Nephropathy Screening* Disparity PIP, HSAG reviewed and provided feedback to Partnership on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Partnership that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the intervention that Partnership tested for its *Diabetes Nephropathy Screening* Disparity PIP. The table also indicates the failure modes that the intervention addressed.

Table 4.2—Partnership *Diabetes Nephropathy Screening* Disparity PIP Intervention Testing

Intervention	Failure Modes Addressed
Train medical assistants to use the template for a nephropathy screening order	♦ Provider does not create a lab order for nephropathy screening. ♦ Medical assistant does not merge the order under standing orders.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Partnership and conducted technical assistance calls with the MCP staff members to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although Partnership completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Partnership's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required Partnership to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, Partnership selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—Partnership *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of *Childhood Immunization Status—Combination 3* measure among beneficiaries residing in Lassen County	35.51%	52.17%

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 3* PIP, HSAG reviewed and provided feedback to Partnership on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to Partnership that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the intervention that Partnership tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the failure mode that the intervention addressed.

Table 4.4—Partnership *Childhood Immunization Status—Combination 3* PIP Intervention Testing

Intervention	Failure Mode Addressed
Review immunization records and outreach to targeted beneficiaries who are close to turning 2 years of age for their final doses of *Childhood Immunization Status—Combination 3* vaccination series.	Track and reach out to beneficiaries missing immunizations between 1 to 2 years of age and get them in before their second birthdays.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to Partnership to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although Partnership completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in Partnership's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, Partnership submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on Partnership's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

[7] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with Partnership, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from Partnership's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of Partnership's self-reported actions.

Table 8.1—Partnership's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP meets all MCP-wide CAP requirements as outlined in the DHCS CAP framework and, in particular, for the following measures with rates below the MPLs for three or more consecutive years in the Northeast Region: a. Both *Annual Monitoring for Patients on Persistent Medications* measures b. *Childhood Immunization Status—Combination 3*	Partnership submitted its comprehensive CAP improvement plan to DHCS on October 9, 2018. To improve HEDIS performance, Partnership partners with its provider network to transform the care delivery system. Our core strategy has three main components: aligned incentives, actionable data, and technical assistance. The CAP improvement plan addresses how the components were being deployed over 2018–19. This plan was reviewed in detail during a November 5, 2018, meeting between Partnership and DHCS. DHCS indicated that Partnership had achieved Milestone 1 of the CAP framework. Partnership has since met with DHCS by phone monthly and in-person quarterly.

2017–18 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
2. Assess whether or not the MCP's current improvement strategies need to be modified or expanded to improve the MCP's performance for the following measures for which the MCP continues to perform below the minimum performance levels: a. *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* in the Northwest Region b. *Childhood Immunization Status—Combination 3* in the Northwest Region c. *Comprehensive Diabetes Care—Medical Attention* for *Nephropathy* in the Northwest and Southwest regions	Partnership prioritized its efforts to increase member awareness and education on the importance of annual lab monitoring events. ***Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*** ♦ Sprint Member Outreach Campaign: A joint quality improvement, care coordination, and utilization management team conducted a plan-wide *Annual Monitoring for Patients on Persistent Medications* member outreach campaign during Quarter 4 2018. This campaign involved Partnership nurses and medical social workers calling members eligible under the *Annual Monitoring for Patients on Persistent Medications* measure for whom Partnership had no record of an annual lab monitoring event completion. The primary objectives were to (1) deliver education about why lab monitoring is important for this population and (2) increase compliance with lab monitoring. During the outreach campaign, 4,130 of 4,689 targeted members were contacted by phone or member-informing mailer. Three phone attempts were made for each member, across varying times and days of the week. Forty-one percent of members reached by phone stated that they were unaware of the need for annual lab monitoring. By April 2019, Partnership observed that 31.3 percent (1,292/4,130) of the members contacted by either phone or mailer completed their labs. Among members successfully reached by both phone and mailer, 32.5 percent of the members completed their labs following the outreach (423/1,301).

2017–18 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	♦ PDSA with a federally qualified health center (FQHC) in Lassen County: A subset of members assigned to the largest provider in Lassen County (Northeast Region) were removed from the Sprint campaign to test a more targeted member outreach strategy from October 2018 through May 2019. This intervention targeted Partnership nurse-to-member one-on-one outreach coupled with the health center's newly implemented standing lab order workflow. The improvement target was exceeded in Cycle 2. The provider adapted and implemented the intervention with these lessons learned: (1) Multi-pronged communication is effective for member-facing interventions, (2) sending the mailer in advance of outreach phone calls enables a more effective phone call, and (3) proactive cross-referencing member contact information is valuable. ***Childhood Immunization Status—Combination 3*** ♦ Immunization Dose Reports: Data analysis revealed an opportunity to focus on members who miss meeting the measure by only one to two doses. Partnership used claims and California Immunization Registry data to manually generate supplemental immunization dosage reports to identify eligible members' progress related to the *Childhood Immunization Status—Combination 3* measure in measurement year 2018. Three Northern Region health centers provided favorable feedback, including how the reports offer a valuable snapshot of all dosage dates by member. Partnership developed automated generation of these reports and in November 2018 offered immunization dose

2017–18 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	reports for all assigned members in the 0–2-year-old age range by site. This expanded view helps providers target all required Year 1 doses for timely completion. In early 2019, provider feedback led Partnership to adopt a plan to offer these reports three times annually. By the end of April 2019, reports covering 22,998 children had been sent to 36 provider organizations. In a recent survey, 96 percent of providers agreed or strongly agreed that the report enabled them to start outreach sooner to achieve vaccination goals. ♦ *Childhood Immunization Status—Combination 3* Northwest Region Media Campaign: In mid-2018, Partnership partnered with providers and other community stakeholders in its Northwest Region to develop an immunization media campaign to positively influence vaccine-hesitant patients. Partnership launched its immunization media campaign on March 1, 2019, titled: "Prepare your Family for a Healthy Future—Immunize by Age 2." This multipronged campaign ran through May 31, 2019, with an objective of increasing *Childhood Immunization Status—Combination 3* measure rates for our 0–2-year-old population in Humboldt and Del Norte counties. The campaign consisted of three main components: health care and community-based organization training, social marketing, and a member outreach toolkit. As of June 30, 2019, Partnership was still measuring the campaign's influence on our community and immunization rates.

2017–18 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	Comprehensive Diabetes Care—Medical Attention for Nephropathy ♦ Partnership partnered with a large Southwest Region health center for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* PIP. The interventions tested focused on workflow modifications for medical assistants to initiate the order and to provide the urine sample cup. There was also testing for the front desk to provide the cup upon registration, but this idea was abandoned due to the complexity of incorporating the electronic health record alert system into the front desk workflow. Another learning was that there are missed screening opportunities, such as same-day visits or health education classes. There was no testing on these ideas after the measure was no longer included in the DHCS Managed Care Accountability Set (MCAS) for reporting year 2020.
3. For the following measures, assess the causes for the MCP's performance below the minimum performance levels in RY 2018 and identify strategies to improve performance: a. *Asthma Medication Ratio* in the Northeast and Northwest regions b. *Breast Cancer Screening* in the Northeast and Northwest regions c. *Childhood Immunization Status—Combination 3* in the Southwest Region d. *Immunizations for Adolescents—Combination 2* in the Northeast Region	***Asthma Medication Ratio*** ♦ Northern Region PDSA with Community Pharmacies: Partnership worked with community pharmacies in the northern regions to test POS messaging workflows. The concept of these workflows is to trigger patient and pharmacy engagement procedures when an eligible member fills a prescription for a rescue inhaler. Partnership predicted that the POS message would increase member engagement and education on the benefits of adding controller medications, leading to more members filling controller medications. Two PDSA cycles with four community pharmacy sites were completed in the Northwest Region. Results exceeded

2017–18 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
e. *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in the Northwest Region	the intervention goals set. Partnership is working to absorb the POS messaging workflow, associated tools, and lessons learned into its 2019–20 *Asthma Medication Ratio* improvement plans. Partnership updated its formulary allowing 90-day refills of controller medications, starting July 1, 2019. ***Breast Cancer Screening*** ♦ Northern Region PDSA with PCP and Imaging Provider: Partnership engaged its largest PCP and imaging provider in the Northeast Region in two 90-day cycles aimed at testing the impact of using the imaging provider's physician portal to simplify the referral process. The intervention leveraged the imaging provider's member outreach process to schedule mammograms. Following PDSA Cycle 2, the targeted goal was exceeded. The PCP agreed to monitor the imaging provider's success in scheduling members designated in the physician portal. PDSA outcomes were widely shared with other providers. ***Childhood Immunization Status—Combination 3*** ♦ In September 2019, Partnership disseminated a dashboard on members' status of *Childhood Immunization Status—Combination 3* dose completion to providers who account for approximately 80 percent of the membership in the Southwest and Southeast regions. This dashboard was well received. (It was replaced by the immunization dose reports in late fall 2019.) In 2017–18, a medium-sized provider focused on *Childhood Immunization Status—Combination 3*

2017–18 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	performance as part of participating in a year-long quality improvement training program. From PDSA testing, lessons learned were as follows: ■ Pairing letters and outreach calls is effective. ■ Cite the State mandate to vaccinate in order to attend public school. ■ Vaccinate siblings who are also present during a PCP visit. ***Immunizations for Adolescents—Combination 2*** ♦ Northern Region *Immunizations for Adolescents—Combination 2* PDSAs: In 2018, Partnership explored PCP-led immunization clinics, with targeted member outreach outside the back-to-school season coupled with an incentive offering. The team learned more than anticipated outreach is needed and offered flexible immunization-only visits. And, it was important to focus on member immunization status well in advance of the member's 13th birthday. After multiple cycles, the provider's performance exceeded the 75th percentile, and the provider shared its work widely. ♦ Adolescent Immunization Poster Campaign: Partnership expanded its successful 2017–18 Adolescent Immunization Poster Contest. The aim was to educate students on the importance of immunizations and offer an opportunity to create posters with a positive immunization message for a contest at their school's open house. Awards were given for posters receiving the most votes among students, parents, and teachers. Post-survey results showed that 37 percent of sixth-graders felt

2017–18 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	their family's opinions on immunizations changed favorably and the *Immunizations for Adolescents—Combination 2* rate for the represented ZIP code improved by 6.76 percentage points seven months after the intervention started. Partnership expanded to five local schools in Shasta County during 2018–19, involving over 450 adolescents. Top vote-getting posters were reproduced and distributed across PCP sites. ♦ Immunization Dose Reports: As stated previously in the actions related to the *Childhood Immunization Status—Combination 3* measure, in April 2019 Partnership refreshed supplemental *Childhood Immunization Status—Combination 3* immunization dose reports. As part of this refresh, Partnership included supplemental immunization dose reports specific to *Immunizations for Adolescents—Combination 2* to help providers identify the progress of assigned members ages 9 to13 years in this immunization series. A total of 106 provider clinics received these reports in April 2019. ***Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*** ♦ Well-Child Birthday Club PDSA/Extended Pilot: Partnership expanded its Birthday Club strategy from the Northeast Region to the Northwest Region in Sept 2018. Provider partners included a private pediatrics provider and two FQHC sites. Multiple 90-day cycles were successfully completed. Primary lessons learned include:

2017–18 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	▪ Reminder telephone calls encouraging members to schedule an appointment are meaningful. ▪ Results suggest the incentive positively influenced completion of *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* visits. ▪ Linking well-child exams to a child's birthday spaces exams over time, mitigating access issues. ▪ Providers reported improved rapport when rewarding the incentive at the visit completion. Partnership further expanded this pilot to all sites of the largest FQHCs in the Northwest and Northeast regions. ♦ HEDIS Value Set Directory Pocket Guide: Quality improvement and claims teams partnered to develop a pocket guide and training materials to help improve provider utilization of the HEDIS Value Set Directory in billing for services under lagging HEDIS measures. The team met with providers to understand how services documented in medical records can be better captured administratively. Training sessions across six counties resulted.
4. Continue monitoring adopted and adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2015–17 *Hypertension* and *Diabetes Retinal Eye Exam* PIPs.	Partnership monitors effective interventions from the *Hypertension* PIP via annual HEDIS performance and its pay-for-performance program. The PIP provider is an active member of the northern consortia, through which best practices are readily shared. The learnings from the *Retinal Eye Exam* PIP have informed an ongoing pilot of EyePACS cameras within a PCP setting. After demonstration of sustainable use, four of six cameras were granted (including the PIP provider) in the Southeast, Southwest, and

2017–18 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	Northeast regions. Two cameras were re-deployed in the Southwest and Northeast regions. Partnership expanded the Current Procedural Terminology codes for which it reimburses to include 92250 and 92227.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Partnership's self-reported actions in Table 8.1 and determined that Partnership adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. Partnership described in detail actions taken during the review period, including actions taken based on lessons learned. HSAG noted that the MCP describes collaborative efforts with various entities, including clinics, PCPs, community groups, imaging providers, and pharmacies. The MCP also described various member outreach efforts to improve members' knowledge of needed health care services and efforts to improve members' access to needed services. While actions related to some measures did not result in improvement in the measures' rates to above the minimum performance levels, the MCP reports positive outcomes that, if successfully spread across more partners and counties, should result in improvement in the measures' rates over time.

2018–19 Recommendations

Based on the overall assessment of Partnership's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Institute monitoring of rejected claims for capitated services to ensure that complete data are received in time for performance measure reporting.
- Increase oversight of the data received from Kaiser to ensure that Kaiser has included all appropriate fields in the data files for performance measure data calculation and conduct ongoing data checks to ensure that corrective actions can be instituted prior to sample selection for hybrid measures as well as rate calculation.
- Determine whether the MCP needs to modify or expand its current strategies to improve the MCP's performance to above the minimum performance levels for the following measures:
  - *Asthma Medication Ratio* in the Northeast, Northwest, and Southwest regions
  - *Breast Cancer Screening* in the Northwest Region
  - *Childhood Immunization Status—Combination 3* in the Northeast and Northwest regions

- *Immunizations for Adolescents—Combination 2* in the Northeast and Northwest regions
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in the Northeast and Northwest regions

In the next annual review, HSAG will evaluate continued successes of Partnership as well as the MCP's progress with these recommendations.

Appendix BB:
Performance Evaluation Report
Rady Children's Hospital—San Diego
July 1, 2018–June 30, 2019

Table of Contents

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted PSP, Rady Children's Hospital—San Diego ("RCHSD" or "the PSP"). The purpose of this appendix is to provide PSP-specific results of each activity and an assessment of the PSP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this PSP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in RCHSD's 2019–20 PSP-specific evaluation report. This PSP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Population-Specific Health Plan Overview

RCHSD is a full-scope MCP delivering services to beneficiaries with specialized health care needs under the PSP model. RCHSD became operational in San Diego County to provide MCMC services effective July 1, 2018. As of June 2019, RCHSD had 368 beneficiaries.[1]

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Population-Specific Health Plan Compliance

DHCS conducted no compliance reviews of RCHSD during the July 1, 2018, through June 30, 2019, review period for this PSP-specific evaluation report. HSAG will report on compliance reviews conducted with the PSP during the July 1, 2019, through June 30, 2020, review period in RCHSD's 2019–20 PSP-specific evaluation report.

3. Population-Specific Health Plan Performance Measures

To comply with federal requirements, DHCS selects a set of performance measures through which to evaluate the quality of care delivered to beneficiaries by contracted MCPs, PSPs, and SHPs (collectively referred to as "plans" in this section). These plans must report county or regional rates unless otherwise approved by DHCS. DHCS refers to the DHCS-selected performance measures for these plans as the External Accountability Set (EAS). By reporting EAS rates to DHCS, these plans provide a standardized method for objectively evaluating their delivery of services to beneficiaries.

To report performance measure rates, a PSP's beneficiaries must meet continuous enrollment requirements for each measure that the PSP is reporting, which means that beneficiaries need to be enrolled in the PSP for 11 of 12 months during the measurement year. Reporting year 2019 performance measure rates reflect data from measurement year 2018 (January 1, 2018, through December 31, 2018). RCHSD began providing MCMC services on July 1, 2018; therefore, no RCHSD MCMC beneficiaries had continuous enrollment during measurement year 2018. Consequently, RCHSD reported no performance measure results, and HSAG did not conduct a National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™[2] of RCHSD for reporting year 2019.

RCHSD will report performance measure rates for the first time in reporting year 2020 (measurement year 2019).

[2] NCQA HEDIS Compliance Audit™ is a trademark of NCQA.

4. Performance Improvement Projects

DHCS requires that each MCP, PSP, and SHP conduct a minimum of two DHCS-approved performance improvement projects (PIPs) per each Medi-Cal contract held with DHCS.

Based on RCHSD providing services starting July 1, 2018, DHCS waived the requirement for the PSP to conduct PIPs during the review period for this PSP-specific evaluation report. In April 2019, HSAG began to provide trainings and technical assistance to RCHSD on the PIP process and requirements so that the PSP will be prepared to conduct PIPs starting in July 2019.

5. Consumer Surveys

DHCS periodically evaluates the perceptions and experiences of beneficiaries as part of its process for assessing the quality of health care services. For full-scope MCPs that are not PSPs, DHCS contracted with HSAG during the July 1, 2018, through June 30, 2019, reporting period to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3] survey instruments.

PSPs are not included in the CAHPS surveys that HSAG conducts and are instead required to administer their own annual consumer satisfaction surveys to evaluate beneficiary satisfaction regarding care and services provided.

RCHSD reported that the PSP is in the process of contracting with a survey vendor and is finalizing its member satisfaction survey instrument. RCHSD originally planned to conduct the PSP's first satisfaction survey one year after beneficiaries' enrollment in the PSP began; however, the PSP indicated that the majority of beneficiaries enrolled six months after the PSP started operations. To ensure a statistically valid survey, RCHSD noted that the PSP needs a critical mass of continuous enrollment and will therefore conduct the survey at a later date.

[3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

6. Recommendations

2018–19 Recommendations

HSAG recommends that RCHSD work with DHCS and HSAG to ensure that the PSP fully understands all EQRO activities and DHCS' requirements of the PSP related to each activity.

In the next annual review, HSAG will evaluate RCHSD's successes related to conducting the required activities as well as how the PSP addressed this recommendation.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix CC:
Performance Evaluation Report
San Francisco Health Plan
July 1, 2018–June 30, 2019

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Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, San Francisco Health Plan ("SFHP" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in SFHP's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

SFHP is a full-scope MCP delivering services to beneficiaries as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in SFHP, the Local Initiative MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan.

SFHP became operational in San Francisco County to provide MCMC services effective January 1997. As of June 2019, SFHP had 126,621 beneficiaries in San Francisco County.[1] This represents 87 percent of the beneficiaries enrolled in San Francisco County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for SFHP. The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of SFHP. A&I conducted the audits from March 5, 2018, through March 16, 2018. These audits included review of the Seniors and Persons with Disabilities (SPD) population in the areas of Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of SFHP
Audit Review Period: March 1, 2017, through February 28, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	Corrective Action Plan (CAP) in process and under review.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	Yes	CAP in process and under review.

Table 2.2 summarizes the results and status of the on-site A&I Medical and State Supported Services Audits of SFHP. A&I conducted the audits from February 25, 2019, through March 1, 2019. The purpose of these audits was to examine documentation for compliance and to determine to what extent SFHP had implemented the MCP's CAP from the prior Medical and State Supported Services Audits for the period of March 1, 2017, through February 28, 2018. DHCS issued the audit reports on July 10, 2019, which is outside the review period for this

report; however, HSAG includes the information from the reports because A&I conducted the on-site audits during the review period for this report.

Table 2.2—DHCS A&I Medical and State Supported Services Audits of SFHP
Audit Review Period: March 1, 2018, through February 28, 2019

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in the Administrative and Organizational Capacity category during the March 5, 2018, through March 16, 2018, Medical Audit of SFHP and no findings in the State Supported Services category during the February 25, 2019, through March 1, 2019, State Supported Services Audit of the MCP.

Opportunities for Improvement—Compliance Reviews

SFHP has the opportunity to work with DHCS to ensure that the MCP fully resolves all findings from the March 5, 2018, through March 16, 2018, and February 25, 2019, through March 1, 2019, Medical and State Supported Services Audits.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for San Francisco Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that SFHP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for SFHP's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

[4] Quality Compass® is a registered trademark of NCQA.

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
SFHP—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	81.48%	83.18%	82.47%	89.54%	7.07
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**93.39%**	**91.96%**	**91.40%**	**93.03%**	1.63

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	90.23%	85.47%	86.25%	85.75%	-0.50
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	93.01%	90.01%	90.38%	88.76%	-1.62
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	89.97%	87.51%	87.92%	87.05%	-0.87
Immunizations for Adolescents—Combination 2	—	39.25%	61.31%	58.16%	-3.15
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	85.42%	87.59%	87.34%	87.10%	-0.24
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	84.26%	84.07%	86.46%	83.70%	-2.76

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	82.18%	82.18%	82.40%	82.80%	0.40

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
SFHP—San Francisco County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	4	5	80.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Rates Above High Performance Levels for the Last Three or More Consecutive Years	3	4	75.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	5	20.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.

- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS

made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain Multi-Year Performance Measure Results SFHP—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	62.66%	61.12%	64.35%	3.23
Cervical Cancer Screening	61.56%	68.72%	70.28%	68.10%	-2.18

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Prenatal and Postpartum Care—Postpartum Care	74.23%	70.83%	73.85%	77.74%	3.89
Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.07%	85.19%	91.09%	86.89%	-4.20

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
SFHP—San Francisco County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	3	33.33%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
SFHP—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.75%	87.85%	87.37%	88.10%	0.73
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.00%	86.85%	86.88%	87.44%	0.56
*Asthma Medication Ratio^*	—	80.02%	79.19%	74.77%	-4.42
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	71.30%	74.71%	72.14%	73.16%	1.02
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	74.07%	70.53%	76.82%	73.16%	-3.66

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	68.29%	63.11%	64.84%	64.74%	-0.10
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	18.98%	26.68%	30.99%	27.11%	-3.88
*Comprehensive Diabetes Care—HbA1c Testing^*	94.44%	90.72%	92.97%	90.00%	-2.97
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	89.58%	88.40%	91.67%	90.26%	-1.41
Controlling High Blood Pressure	—	—	—	71.29%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
SFHP—San Francisco County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	4	9	44.44%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	2	8	25.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	9	11.11%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	9	0.00%

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
SFHP—San Francisco County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	34.77	37.28	38.12	39.07	Not Tested

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	356.17	338.64	344.41	383.61	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	43.14%	48.43%	53.93%	51.32%	-2.61
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	0.55%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	65.99%	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	19.84%	Not Comparable
Use of Imaging Studies for Low Back Pain	81.58%	76.64%	81.03%	82.43%	1.40

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
SFHP—San Francisco County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	2	2	100.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	1	2	50.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of SFHP's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
SFHP—San Francisco County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	11	19	57.89%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Rates Above High Performance Levels for the Last Three or More Consecutive Years	6	16	37.50%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	19	0.00%

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the SPD population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD/Non-SPD Rate Difference" column in Table 3.12.

Table 3.10—Multi-Year SPD Performance Measure Trend Table
SFHP—San Francisco County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	87.38	94.53	87.07	92.13	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	592.07	568.12	533.64	602.95	Not Tested

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.23%	87.34%	88.32%	89.04%	0.72
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.43%	87.70%	88.33%	90.17%	1.84
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	84.80%	80.70%	84.34%	79.79%	-4.55
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	88.52%	84.57%	85.80%	81.71%	-4.09
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	84.69%	81.19%	76.00%	78.50%	2.50
*Plan All-Cause Readmissions***	—	—	—	25.31%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
SFHP—San Francisco County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	28.69	31.46	33.36	33.93	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	328.91	315.31	325.97	362.33	Not Tested

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.03%	88.09%	86.97%	87.66%	0.69
Annual Monitoring for Patients on Persistent Medications—Diuretics	87.35%	86.41%	86.17%	85.98%	-0.19
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	93.41%	91.99%	91.53%	93.06%	1.53
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	90.30%	85.53%	86.27%	85.81%	-0.46
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	93.11%	90.14%	90.49%	88.92%	-1.57
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	90.14%	87.70%	88.28%	87.29%	-0.99
*Plan All-Cause Readmissions***	—	—	—	15.88%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations SFHP—San Francisco County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	92.13	33.93	Not Tested	39.07
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	602.95	362.33	Not Tested	383.61
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.04%	87.66%	1.38	88.10%
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.17%	85.98%	4.19	87.44%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	93.06%	Not Comparable	93.03%

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	79.79%	85.81%	-6.02	85.75%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	81.71%	88.92%	-7.21	88.76%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	78.50%	87.29%	-8.79	87.05%
*Plan All-Cause Readmissions***	25.31%	15.88%	9.43	19.84%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that SFHP stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, SFHP had no statistically significant variation in SPD rates from reporting year 2018 to reporting year 2019.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly worse than the reporting year 2018 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* measures.
- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rate was significantly better than the reporting year 2019 non-SPD rate for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure.
  - The reporting year 2019 SPD rates were significantly worse than the reporting year 2019 non-SPD rates for the following measures:
    - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*. The significant differences in rates for these measures may be attributed to beneficiaries in these age groups in the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from primary care providers (PCPs).

- *Plan All-Cause Readmissions*. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that SFHP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for SFHP:

- Across all domains, SFHP performed above the high performance levels for 11 of 19 measures (58 percent) and had no rates below the minimum performance levels.
- The rates for the following six measures were above the high performance levels for at least three consecutive years:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
  - *Childhood Immunization Status—Combination 3*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
  - Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measures
- The rates for the following two measures improved significantly from reporting year 2018 to reporting year 2019:
  - *Breast Cancer Screening*
  - *Childhood Immunization Status—Combination 3*

Opportunities for Improvement—Performance Measures

Based on SFHP's reporting year 2019 performance measure results, HSAG has no recommendations for the MCP in the area of performance measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, SFHP conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's module submissions for both these PIPs as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required SFHP to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, SFHP identified postpartum care among African-American beneficiaries as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—SFHP *Postpartum Care* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of postpartum visits that occur with an obstetrician/gynecologist (OB/GYN) or PCP within three to eight weeks of delivery among African-American beneficiaries who deliver at Hospital A[6]	62%	91%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Postpartum Care* Disparity PIP. Upon initial review of the module, HSAG determined that SFHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the failure modes and effects analysis table.
- Describing the priority-ranking process.
- Considering the potential interventions' reliability and sustainability.

After receiving technical assistance from HSAG, SFHP incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

[6] Hospital name removed for confidentiality.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Postpartum Care* Disparity PIP, HSAG reviewed and provided feedback to SFHP on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to SFHP that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the intervention that SFHP tested for its *Postpartum Care* Disparity PIP. The table also indicates the failure modes that the intervention addressed.

Table 4.2—SFHP *Postpartum Care* Disparity PIP Intervention Testing

Intervention	Failure Modes Addressed
Test the effectiveness of a new electronic tracking system to flag and identify beneficiaries who recently delivered babies to schedule postpartum care visits within three to eight weeks of delivery using appointment scheduling protocols.	♦ Postpartum visits are not automatically scheduled upon discharge. ♦ Postpartum visits are scheduled outside of the compliance window.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to SFHP and conducted technical assistance calls with MCP staff members to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although SFHP completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in SFHP's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required SFHP to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. However, based on SFHP demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. SFHP selected immunizations among adolescent beneficiaries as its 2017–19 DHCS-priority PIP topic based on its MCP-specific data.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—SFHP *Immunizations for Adolescents—Combination 2* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of human papillomavirus (HPV) vaccinations among adolescent beneficiaries who turn 13 years of age	55.2%	59.3%

Performance Improvement Project Validation Findings

During the review period for this report, SFHP incorporated HSAG's initial validation feedback into Module 3 of the *Immunizations for Adolescents—Combination 2* PIP. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Immunizations for Adolescents—Combination 2* PIP, HSAG reviewed and provided feedback to SFHP on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to SFHP that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the interventions that SFHP tested for its *Immunizations for Adolescents—Combination 2* PIP. The table also indicates the key drivers and failure modes that each intervention addressed.

Table 4.4—SFHP *Immunizations for Adolescents—Combination 2* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Provide training to select providers with low HPV vaccine completion rates on how to address challenges and/or concerns among adolescents and parents around HPV, HPV-related issues tailored to patient population, and strategies for working with parents.	♦ Beneficiary/parent is not provided with information about how the two doses of the HPV vaccine need to be received in a timely manner for effectiveness. ♦ Need for the second dose of the HPV vaccine. ♦ Lack of discussion between parent and provider regarding the importance of the HPV vaccine.

Intervention	Key Drivers and Failure Modes Addressed
Provide incentives to clinic staff to conduct beneficiary outreach using immunization registry.	♦ Beneficiary does not return for second HPV vaccine dosage. ♦ Lack of beneficiary engagement to receive both doses of the HPV vaccine in a timely manner.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to SFHP and conducted technical assistance calls with the MCP staff members to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although SFHP completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in SFHP's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, SFHP submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on SFHP's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

[7] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with SFHP, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from SFHP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of SFHP's self-reported actions.

Table 8.1—SFHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Assess the causes for the *Breast Cancer Screening* measure rate declining significantly from RY 2017 to RY 2018, and identify strategies to ensure that female beneficiaries ages 50 to 74 have a mammogram to screen for breast cancer within the appropriate time frame.	SFHP continues to work on discovering the cause of the *Breast Cancer Screening* rate declining significantly. Thus far, SFHP has convened an interdepartmental working group to complete a root cause analysis. Additionally, SFHP has begun surveying providers to better understand how they are tracking the services and results of their referrals. SFHP is also currently analyzing our data to answer the research questions and gain insight into what is impacting our rate. Based on our *Breast Cancer Screening* rate discovery results, we plan to build a meaningful intervention to increase the rate of members receiving appropriate breast cancer screenings.

2017–18 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
2. Continue monitoring adopted and adapted interventions and outcomes to facilitate improvement beyond the life of the 2015–17 *Postpartum Care* and *Patient Experience* PIPs.	The 2015–17 *Patient Experience* PIP consisted of two pilot interventions. The first was customer service representatives adopting the best practice of using key words at key times when answering calls from members. This intervention proved to be effective in improving members' experiences with customer service and has since been adapted by SFHP. The intervention has been expanded to include MAGIC (Making A Great Impression on your Customers) training, which incorporates language that was introduced in the original intervention. All calls made to customer service representatives are audited and scored on the utilization of the MAGIC approach. Our internal goal is to score an average of at least 30 out of 33 points on calls with our members. We reached our goal in fiscal year 2018–19 with an average of 30.5 points and will continue to monitor and internally report these rates. The second pilot intervention was utilizing three-way calls with the Medi-Cal office when members needed resolutions requiring this strategy. Though this measure was successful in impacting our key driver of member engagement, SFHP decided to abandon the intervention to decrease member wait times. SFHP's 2015–17 *Postpartum Care* PIP intervention was to train a network provider team on postpartum care, disparities, and motivational interviewing techniques. This intervention was abandoned as the collaborating provider group chose to focus on other priorities.

2017–18 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
3. Apply lessons learned from the 2015–17 *Postpartum Care* PIP to the 2017–19 *Postpartum Care* Disparity PIP.	As noted above, the 2015–17 *Postpartum Care* PIP intervention was abandoned, thus reducing our effectiveness for meaningful collaboration. From this experience SFHP learned that a more targeted approach is required when looking into potential collaborations. A few key lessons learned that were applied to the 2017–19 *Postpartum Care* Disparity PIP were: ♦ Appropriately scoping the project to be a smaller test of change with the ability to then scale up if effective. ♦ Creating an intervention that better matches the capabilities and structure of the group with which we are working. ♦ Choosing a provider group that has the interest and infrastructure to implement changes. These lessons led us to approach a provider group already focused on reducing disparities and eager to collaborate with us. Because of this, we were able to choose and scope our interventions appropriately after our failure modes and effects analysis.

Assessment of MCP's Self-Reported Actions

HSAG reviewed SFHP's self-reported actions in Table 8.1 and determined that SFHP adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. SFHP described actions taken during the review period, lessons learned, and steps the MCP plans to take moving forward. HSAG identified the following notable actions taken by the MCP in response to the 2017–18 EQRO recommendations:

- To improve beneficiary experience scores, the MCP adapted an intervention from the MCP's 2015–17 *Patient Experience* PIP that tested customer service representatives adopting the use of key words at key times when answering beneficiary calls. The MCP also expanded the intervention to include staff training and reported reaching the MCP's 2018–19 goal.

- The MCP applied lessons learned when making decisions about whether to continue or abandon interventions and when developing its 2017–19 *Postpartum Care* Disparity PIP.

2018–19 Recommendations

Based on the overall assessment of SFHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that SFHP work with DHCS to ensure that the MCP fully resolves all findings from the March 5, 2018, through March 16, 2018, and February 25, 2019, through March 1, 2019, Medical and State Supported Services Audits.

In the next annual review, HSAG will evaluate continued successes of SFHP as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix DD:
Performance Evaluation Report
Santa Clara Family Health Plan
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Santa Clara Family Health Plan ("SCFHP" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in SCFHP's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

SCFHP is a full-scope MCP delivering services to beneficiaries as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in SCFHP, the Local Initiative MCP; or in Anthem Blue Cross Partnership Plan, the alternative commercial plan.

SCFHP became operational in Santa Clara County to provide MCMC services effective February 1997. As of June 2019, SCFHP had 239,099 beneficiaries.[1] This represents 78 percent of the beneficiaries enrolled in Santa Clara County.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for SCFHP. Unless noted, HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2019). The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the 2018 on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of SCFHP. A&I conducted the audits from April 9, 2018, through April 20, 2018.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of SCFHP
Audit Review Period: April 1, 2017, through March 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP imposed and findings in this category rectified.
Case Management and Coordination of Care	Yes	CAP imposed and findings in this category rectified.
Access and Availability of Care	Yes	CAP imposed and findings in this category rectified.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	No	No findings.
Administrative and Organizational Capacity	Yes	CAP imposed and findings in this category rectified.
State Supported Services	No	No findings

Table 2.2 summarizes the results and status of the 2019 on-site DHCS A&I Medical and State Supported Services Audits of SCFHP. A&I conducted the audits from March 18, 2019, through March 29, 2019. Note that DHCS issued the audit reports on July 11, 2019, which is outside the review period for this report; however, HSAG includes the information from the reports because the audits took place during the review period.

Table 2.2—DHCS A&I Medical and State Supported Services Audits of SCFHP
Audit Review Period: April 1, 2018, through February 28, 2019

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	No	No findings.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

SCFHP's CAP response regarding the findings from the 2018 A&I Medical and State Supported Services Audits resulted in DHCS closing the CAP. For the 2019 A&I Medical and State Supported Services Audits, A&I identified no findings in the Access and Availability of Care, Administrative and Organizational Capacity, and State Supported Services categories.

Opportunities for Improvement—Compliance Reviews

SCFHP has the opportunity to work with DHCS to ensure that the MCP fully resolves all findings from the 2019 A&I Medical and State Supported Services Audits of SCFHP. The MCP had findings in four of the seven categories A&I reviewed during the 2019 audits, and the findings cut across the areas of quality and timeliness of, and access to, health care.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for Santa Clara Family Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that SCFHP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results and Findings

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.9 for SCFHP's performance measure results for reporting years 2016 through 2019 and performance measure findings for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all four years.

Note the following regarding Table 3.1 through Table 3.9:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.8 present the performance measure results and findings by domain, and Table 3.9 presents the reporting year 2019 performance measure findings for the domains combined.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Preventive Screening and Children's Health

Table 3.1 presents the four-year trending information for the performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.1:

- Due to changes that NCQA made to the *Childhood Immunization Status—Combination 3* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Childhood Immunization Status—Combination 3* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the four *Children and Adolescents' Access to Primary Care* measures, DHCS did not hold MCPs accountable to meet the minimum performance levels for these measures for reporting years 2016 through 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measures were below the minimum performance levels) and did not hold MCPs accountable to address declining rates for these measures. DHCS made these decisions due to the small range of variation between the high performance level and minimum performance level thresholds for each measure. While DHCS did not require MCPs to submit formal IPs for these measures if the rates were below the minimum performance levels, DHCS expects MCPs to work on opportunities for improvement related to child and adolescent access to health care. Based on DHCS' decisions, HSAG does not include these four measures in its assessment of the MCP's performance.

[4] Quality Compass® is a registered trademark of NCQA.

Table 3.1—Preventive Screening and Children's Health Domain
Multi-Year Performance Measure Results
SCFHP—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Childhood Immunization Status—Combination 3^*	72.02%	77.37%	77.62%	73.72%	-3.90
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**92.58%**	**92.60%**	**87.74%**	95.42%	7.68

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	85.58%	**84.66%**	**78.55%**	87.92%	9.37
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.47%	88.98%	**86.12%**	90.28%	4.16
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	**86.09%**	**85.25%**	**82.85%**	87.24%	4.39
Immunizations for Adolescents—Combination 2	—	36.50%	50.36%	48.91%	-1.45
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	63.50%	68.13%	71.78%	72.75%	0.97

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	53.04%	65.45%	66.67%	65.94%	-0.73
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.45%	73.97%	72.75%	76.16%	3.41

Table 3.2 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Children's Health domain.

Note the following regarding Table 3.2:

- DHCS did not hold MCPs accountable to meet minimum performance levels for all four *Children and Adolescents' Access to Primary Care* measures within this domain and did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings.
- The *Immunizations for Adolescents—Combination 2* measure was a first-year measure in reporting year 2017, and DHCS established no minimum performance level for this measure for reporting year 2017 because no comparable benchmark existed; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.

Table 3.2—Preventive Screening and Children's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings SCFHP—Santa Clara County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	5	20.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	5	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	4	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	5	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	5	0.00%

Preventive Screening and Women's Health

Table 3.3 presents the four-year trending information for the performance measures within the Preventive Screening and Women's Health domain.

Note the following regarding Table 3.3:

- Due to changes that NCQA made to the *Breast Cancer Screening* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Breast Cancer Screening* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- Although HSAG includes information on the MCP's performance related to the *Cervical Cancer Screening* measure, DHCS did not hold MCPs accountable to meet the minimum performance level for this measure for reporting year 2019 (i.e., DHCS did not require MCPs to submit IPs if rates for the measure were below the minimum performance level) and did not hold MCPs accountable to address declining rates for this measure. DHCS made this decision due to the NCQA HEDIS *Cervical Cancer Screening* measure specification not being in alignment with the August 2018 U.S. Preventive Services Task Force cervical cancer screening recommendations. Requiring the MCPs to follow the NCQA measure specifications, therefore, could have resulted in unnecessary testing. Based on DHCS' decisions, HSAG does not include this measure in its assessment of the MCP's performance.

Table 3.3—Preventive Screening and Women's Health Domain
Multi-Year Performance Measure Results
SCFHP—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Breast Cancer Screening^*	—	60.25%	60.74%	64.21%	3.47
Cervical Cancer Screening	**50.36%**	57.42%	54.26%	61.07%	6.81
Prenatal and Postpartum Care—Postpartum Care	64.23%	68.61%	69.10%	71.78%	2.68
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.56%	82.48%	83.70%	86.86%	3.16

Table 3.4 presents findings for the reporting year 2019 performance measures within the Preventive Screening and Women's Health domain. Note the following regarding Table 3.4:

- The *Breast Cancer Screening* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations of the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- DHCS did not hold MCPs accountable to meet the minimum performance level in reporting year 2019 for the *Cervical Cancer Screening* measure and did not hold MCPs accountable to address declining rates for this measure; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.4—Preventive Screening and Women's Health Domain Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings SCFHP—Santa Clara County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	3	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	3	33.33%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	3	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	3	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	3	0.00%

Care for Chronic Conditions

Table 3.5 presents the four-year trending information for the performance measures within the Care for Chronic Conditions domain.

Note the following regarding Table 3.5:

- Due to changes that NCQA made to the specifications for the following measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance:
  - *Asthma Medication Ratio*
  - All six *Comprehensive Diabetes Care* measures
- Although MCPs reported rates for the *Controlling High Blood Pressure* measure in prior years, HSAG displays the reporting year 2019 rate only for this measure in Table 3.5. This is due to changes that NCQA made to the *Controlling High Blood Pressure* measure specification in reporting year 2019, resulting in NCQA recommending a break in trending for this measure. The *Controlling High Blood Pressure* measure was considered a first-year measure in reporting year 2019; therefore, DHCS did not hold MCPs accountable to meet the established minimum performance level for this measure (i.e., DHCS did not require MCPs to submit IPs if rates for this measure were below the minimum performance level). Based on the measure being a first-year measure, HSAG does not display comparison to the minimum performance level and does not include the measure in its assessment of MCP performance.

Table 3.5—Care for Chronic Conditions Domain
Multi-Year Performance Measure Results
SCFHP—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	87.01%	86.42%	88.59%	89.19%	0.60
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.39%	86.00%	88.90%	89.18%	0.28
*Asthma Medication Ratio^*	—	**44.94%**	67.48%	64.87%	-2.61
*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)^*	**37.96%**	59.37%	62.53%	62.29%	-0.24
*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed^*	51.09%	62.29%	63.02%	64.72%	1.70

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)^*	60.10%	53.77%	54.50%	46.23%	-8.27
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)^*	32.36%	37.23%	34.06%	43.31%	9.25
*Comprehensive Diabetes Care—HbA1c Testing^*	86.37%	88.32%	88.32%	89.78%	1.46
*Comprehensive Diabetes Care—Medical Attention for Nephropathy^*	85.64%	88.81%	**86.62%**	90.27%	3.65
Controlling High Blood Pressure	—	—	—	56.93%	Not Comparable

Table 3.6 presents findings for the reporting year 2019 performance measures within the Care for Chronic Conditions domain. Note the following regarding Table 3.6:

- The *Asthma Medication Ratio* measure was a first-year measure in reporting year 2017, and DHCS did not hold MCPs accountable to meet a minimum performance level for this measure in reporting year 2017; therefore, HSAG did not include this measure in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years.
- The *Controlling High Blood Pressure* measure was a first-year measure in reporting year 2019; therefore, HSAG excluded this measure from the calculations for all findings.

Table 3.6—Care for Chronic Conditions Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
SCFHP—Santa Clara County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	9	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	9	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	9	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	8	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	9	22.22%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	8	0.00%

Assessment of Improvement Plans—Care for Chronic Conditions

Based on reporting year 2018 performance measure results, DHCS required SCFHP to submit an IP for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure. SCFHP conducted two PDSA cycles to test whether conducting a beneficiary mailer outreach intervention would result in beneficiaries contacting the MCP's outreach team for assistance with scheduling appointments to complete beneficiaries' needed screenings. The mailer included information about the importance of screening for nephropathy and information about a beneficiary incentive for completing the screening.

The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate improved to above the minimum performance level in reporting year 2019.

Appropriate Treatment and Utilization

Table 3.7 presents the four-year trending information for the performance measures within the Appropriate Treatment and Utilization domain.

Note the following regarding Table 3.7:

- The two *Ambulatory Care* measures are utilization measures, which measure the volume of services used. DHCS does not hold MCPs accountable to meet minimum performance levels for utilization measures, and HSAG does not compare performance for these measures against high performance levels and minimum performance levels. Additionally, because high and low rates do not necessarily indicate better or worse performance, HSAG did not compare performance for these measures across years.
  - Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of specification changes.
- Due to changes that NCQA made to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure specification in reporting year 2019, NCQA released guidance to exercise caution when trending the results for this measure. Therefore, caution should be used when comparing MCP performance across years or when comparing MCP results to benchmarks related to the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, as differences in rates may be the result of specification changes rather than a reflection of performance.
- HSAG did not assess the MCP's performance related to the two *Depression Screening and Follow-Up for Adolescents and Adults* measures, based on the following:
  - DHCS established no high performance levels or minimum performance levels for reporting year 2019 because no comparable benchmarks exist.
  - Although MCPs reported these two measures for reporting year 2018, HSAG does not present the reporting year 2018 performance measure results for these measures in this report because the reporting year 2018 reported rates did not accurately represent services being provided. This was due to the *Depression Screening and Follow-Up for Adolescents and Adults* measures being new HEDIS measures for reporting year 2018, NCQA requiring MCPs to submit rates for these measures using the new electronic clinical data systems (ECDS) reporting methodology, and inconsistent data reporting processes by calculation vendors. Thus, MCPs experienced numerous challenges obtaining data sources to use for ECDS reporting.
- Reporting year 2019 was the first year that DHCS required MCPs to report rates for the *Plan All-Cause Readmissions* measure, and DHCS established no high performance level or minimum performance level for this measure because no comparable benchmarks exist; therefore, HSAG does not include the measure in its assessment of MCP performance.

Table 3.7—Appropriate Treatment and Utilization Domain
Multi-Year Performance Measure Results
SCFHP—Santa Clara County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

^ Caution should be exercised when assessing MCP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	35.65	34.12	38.00	38.14	Not Tested

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	262.31	240.19	224.59	318.89	Not Tested
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis^*	30.99%	31.93%	38.52%	36.33%	-2.19
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	—	—	—	0.88%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	—	—	—	73.90%	Not Comparable
*Plan All-Cause Readmissions***	—	—	—	18.65%	Not Comparable
Use of Imaging Studies for Low Back Pain	78.86%	74.40%	76.03%	75.41%	-0.62

Table 3.8 presents findings for the reporting year 2019 performance measures within the Appropriate Treatment and Utilization domain. DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures within this domain, and HSAG made no performance comparison from reporting year 2018 to reporting year 2019 for these measures; therefore, HSAG excluded these measures from the calculations for all findings:

- Both *Ambulatory Care* measures
- Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
- *Plan All-Cause Readmissions*

Table 3.8—Appropriate Treatment and Utilization Domain
Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings
SCFHP—Santa Clara County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

N/A = No rates above or below the minimum performance levels from the previous year exist to include in the denominator for calculating whether or not rates moved to above or below minimum performance levels in the most recent year.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	0	2	0.00%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	0	0	N/A
Reporting Year 2019 Rates Below Minimum Performance Levels	0	2	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	2	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	0	2	0.00%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	2	0.00%

Performance Measure Findings—All Domains

Table 3.9 presents a summary of SCFHP's reporting year 2019 performance across all External Accountability Set (EAS) measures.

Note the following regarding Table 3.9:

- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures and/or did not hold MCPs accountable to address declining rates for these measures; therefore, HSAG excluded these measures from the calculations for all findings:
  - Both *Ambulatory Care* measures
  - *Cervical Cancer Screening*
  - All four *Children and Adolescents' Access to Primary Care* measures
  - *Controlling High Blood Pressure*
  - Both *Depression Screening and Follow-Up for Adolescents and Adults* measures
  - *Plan All-Cause Readmissions*
- DHCS did not hold MCPs accountable to meet minimum performance levels for the following measures in reporting year 2017; therefore, HSAG did not include these measures in the calculations for the percentage of measures with rates above the high performance levels for the last three or more consecutive years or below the minimum performance levels for the last three or more consecutive years:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*

Table 3.9—Reporting Year 2019 (Measurement Year 2018) Performance Measure Findings for All Domains
SCFHP—Santa Clara County

* Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Above High Performance Levels	1	19	5.26%
Rates Above High Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%

Criteria	Number of Measures Meeting Criteria	Total Number of Measures	Percentage of Measures Meeting Criteria
Reporting Year 2019 Rates Significantly Better than Reporting Year 2018 Rates*	1	19	5.26%
Rates that Moved from Below Minimum Performance Levels in Reporting Year 2018 to Above Minimum Performance Levels in Reporting Year 2019	1	1	100.00%
Reporting Year 2019 Rates Below Minimum Performance Levels	0	19	0.00%
Rates Below Minimum Performance Levels for Only the Last Two Consecutive Years	0	19	0.00%
Rates Below Minimum Performance Levels for the Last Three or More Consecutive Years	0	16	0.00%
Reporting Year 2019 Rates Significantly Worse than Reporting Year 2018 Rates*	2	19	10.53%
Rates that Moved from Above Minimum Performance Levels in Reporting Year 2018 to Below Minimum Performance Levels in Reporting Year 2019	0	18	0.00%

Seniors and Persons with Disabilities Performance Measure Results

Table 3.10 presents the four-year trending information for the Seniors and Persons with Disabilities (SPD) population, and Table 3.11 presents the four-year trending information for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. The tables also show the differences in rates between reporting year 2018 and reporting year 2019.

Table 3.12 presents the SPD and non-SPD rates, a comparison of the SPD and non-SPD rates,[5] and the total combined rate for each measure.

Table 3.10—Multi-Year SPD Performance Measure Trend Table
SCFHP—Santa Clara County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2018 SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2018 SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

[5] HSAG calculated statistical significance between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the “SPD/Non-SPD Rate Difference” column in Table 3.12.

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	45.34	46.23	49.68	46.42	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	446.55	436.74	395.48	509.50	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	88.83%	88.66%	90.52%	90.71%	0.19
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.19%	90.05%	92.03%	91.56%	-0.47
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	NA	NA	NA	Not Comparable
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	80.76%	80.54%	78.13%	81.73%	3.60
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.10%	88.26%	82.34%	82.03%	-0.31

Measure	Reporting Year 2016 SPD Rate	Reporting Year 2017 SPD Rate	Reporting Year 2018 SPD Rate	Reporting Year 2019 SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	78.28%	78.80%	76.41%	80.14%	3.73
*Plan All-Cause Readmissions***	—	—	—	26.40%	Not Comparable

Table 3.11—Multi-Year Non-SPD Performance Measure Trend Table
SCFHP—Santa Clara County

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly better than the reporting year 2018 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 non-SPD rate is significantly worse than the reporting year 2018 non-SPD rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's “contribution” to the total yearly membership.

** A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

Not Comparable = A reporting year 2018–19 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	34.88	33.06	37.05	37.42	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	247.61	223.06	210.75	302.31	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.13%	85.19%	87.66%	88.42%	0.76
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.16%	83.69%	87.50%	88.01%	0.51
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	92.60%	92.63%	87.78%	95.50%	7.72
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	85.64%	84.73%	78.56%	88.04%	9.48
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	89.57%	89.00%	86.23%	90.53%	4.30

Measure	Reporting Year 2016 Non-SPD Rate	Reporting Year 2017 Non-SPD Rate	Reporting Year 2018 Non-SPD Rate	Reporting Year 2019 Non-SPD Rate	Reporting Years 2018–19 Rate Difference
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	86.40%	85.48%	83.07%	87.48%	4.41
*Plan All-Cause Readmissions***	—	—	—	15.22%	Not Comparable

Table 3.12—Reporting Year 2019 (Measurement Year 2018) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations SCFHP—Santa Clara County

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly better than the reporting year 2019 non-SPD rate.

= Statistical testing result indicates that the reporting year 2019 SPD rate is significantly worse than the reporting year 2019 non-SPD rate.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

Total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2019 SPD Rate	Reporting Year 2019 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2019 Total Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	46.42	37.42	Not Tested	38.14
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	509.50	302.31	Not Tested	318.89
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.71%	88.42%	2.29	89.19%
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.56%	88.01%	3.55	89.18%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA	95.50%	Not Comparable	95.42%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	81.73%	88.04%	-6.31	87.92%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	82.03%	90.53%	-8.50	90.28%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	80.14%	87.48%	-7.34	87.24%
*Plan All-Cause Readmissions***	26.40%	15.22%	11.18	18.65%

Seniors and Persons with Disabilities Findings

HSAG observed the following notable results in reporting year 2019 for measures that SCFHP stratified by the SPD and non-SPD populations:

- For SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 SPD rate was significantly better than the 2018 SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* measure.
- For non-SPD rates for which HSAG could make a comparison between reporting year 2018 and reporting year 2019, the reporting year 2019 non-SPD rates were significantly better

than the reporting year 2018 non-SPD rates for all four *Children and Adolescents' Access to Primary Care Practitioners* measures.

- For measures for which HSAG could make a comparison between the reporting year 2019 SPD rates and reporting year 2019 non-SPD rates:
  - The reporting year 2019 SPD rates were significantly better than the reporting year 2019 non-SPD rates for both *Annual Monitoring for Patients on Persistent Medications* measures.
  - The reporting year 2019 SPD rates were significantly worse than the reporting year 2019 non-SPD rates for the following measures:
    - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*. The significant differences in rates for these measures may be attributed to beneficiaries in these age groups in the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from primary care providers (PCPs).
    - *Plan All-Cause Readmissions*. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that SCFHP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

HSAG identified the following notable reporting year 2019 performance measure results for SCFHP:

- The *Immunizations for Adolescents—Combination 2* measure rate was above the high performance level.
- The *Breast Cancer Screening* measure rate improved significantly from reporting year 2018 to reporting year 2019.
- The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate moved from below the minimum performance level in reporting year 2018 to above the minimum performance level in reporting year 2019.

Opportunities for Improvement—Performance Measures

SCFHP has the opportunity to identify the causes for the MCP's performance declining significantly from reporting year 2018 to reporting year 2019 for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure and to develop strategies, as applicable, to address the significant decline in performance. Note that NCQA made specification changes in reporting year 2019 for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0*

Percent) measure; therefore, the significant decline in the MCP's performance may be due to NCQA's specification changes.

Note that the *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* measure rate declined significantly from reporting year 2018 to reporting year 2019. While SCFHP has opportunities for improvement related to this measure, HSAG makes no formal recommendations because DHCS will not require MCPs to report the measure to DHCS in reporting year 2020, and DHCS and HSAG will therefore have no way to follow up on the outcomes of the MCP's quality improvement actions related to the measure. DHCS and HSAG expect that SCFHP will continue to engage in continuous quality improvement strategies to ensure beneficiaries are receiving needed health care services and that the MCP will conduct improvement activities, as applicable, related to the *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* measure.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to SCFHP's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that SCFHP report rates for three HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the rates for each required MLTSSP performance measure for reporting years 2016 through 2019. The reporting year is the year in which the MLTSSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that the *Ambulatory Care—Emergency Department Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures which measure the volume of services used. High and low rates do not necessarily indicate better or worse performance; therefore, for these measures, HSAG did not compare performance between reporting year 2018 and reporting year 2019. Note that NCQA made changes to the *Ambulatory Care—Outpatient Visits* measure specification in reporting year 2019; therefore, any variation in the rate for this measure from reporting year 2018 to reporting year 2019 may be the result of those changes.

Table 4.1—Multi-Year MLTSSP Performance Measure Results
SCFHP—Santa Clara County

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2016 rates reflect measurement year data from January 1, 2015, through December 31, 2015.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's "contribution" to the total yearly membership.

Not Tested = A reporting year 2018–19 rate difference was not calculated because high and low rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2016 Rate	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	46.68	46.30	51.66	51.09	Not Tested
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	351.61	347.94	343.24	445.12	Not Tested
Medication Reconciliation Post-Discharge	20.44%	44.28%	42.09%	11.92%	-30.17

Managed Long-Term Services and Supports Plan Performance Measure Findings

The *Medication Reconciliation Post-Discharge* measure rate declined significantly from reporting year 2018 to reporting year 2019. SCFHP may consider assessing the causes for the rate for this measure declining significantly to ensure that beneficiaries 18 years of age and older who are discharged from acute or nonacute inpatient care have their medications reconciled by 30 days after discharge.

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, SCFHP conducted one Disparity PIP and one DHCS-priority PIP. In this report, HSAG includes summaries of the MCP's Disparity and DHCS-priority PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required SCFHP to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, SCFHP identified immunizations among Vietnamese children as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.1—SCFHP *Childhood Immunization Status—Combination 3* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Childhood Immunization Status—Combination 3 measure rate among Vietnamese beneficiaries assigned to Provider Network C.[6]	6.3%	25.0%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the MCP's *Childhood Immunization Status—Combination 3* Disparity PIP. Upon initial review of the module, HSAG determined that SCFHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Supporting the sub-processes selection for the FMEA table.
- Including all required components of the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

[6] Provider network name removed for confidentiality.

After receiving technical assistance from HSAG, SCFHP incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Childhood Immunization Status—Combination 3* Disparity PIP, HSAG reviewed and provided feedback to SCFHP on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to SCFHP that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.2 presents a description of the intervention that SCFHP tested for its *Childhood Immunization Status—Combination 3* Disparity PIP. The table also indicates the failure mode that the intervention addressed.

Table 5.2—SCFHP *Childhood Immunization Status—Combination 3* Disparity PIP Intervention Testing

Intervention	Failure Mode Addressed
Provide beneficiary incentive for beneficiaries to obtain immunizations according to the immunization schedule.	Beneficiaries do not prioritize scheduling appointments to complete immunizations according to the immunization schedule.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to SCFHP to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although SCFHP completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in SCFHP's 2019–20 MCP-specific evaluation report.

DHCS-Priority Performance Improvement Project

DHCS required SCFHP to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on the MCP's reporting year 2017 performance measure results, SCFHP selected controlling high blood pressure as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 5.3—SCFHP *Controlling High Blood Pressure* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of adequately controlled blood pressure during the previous rolling 12-month period among beneficiaries ages 18 to 85, diagnosed with hypertension and assigned to Clinic A.[7]	26.47%	50.00%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the MCP's *Controlling High Blood Pressure* PIP. Upon initial review of the module, HSAG determined that SCFHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Including all required components of the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, SCFHP incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the MCP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the MCP's *Controlling High Blood Pressure* PIP, HSAG reviewed and provided feedback to SCFHP on the Plan portion of the PDSA cycle for the intervention that the MCP selected to test. HSAG indicated to SCFHP that the MCP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 5.4 presents a description of the intervention that SCFHP tested for its *Controlling High Blood Pressure* PIP. The table also indicates the failure mode that the intervention addressed.

[7] Clinic name removed for confidentiality.

Table 5.4—SCFHP *Controlling High Blood Pressure* PIP Intervention Testing

Intervention	Failure Mode Addressed
Provide beneficiary incentive for controlling blood pressure.	Beneficiaries are aware of appointments to measure blood pressure but do not attend them.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to SCFHP to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although SCFHP completed testing the intervention through the SMART Aim end date of June 30, 2019, the MCP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this MCP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in SCFHP's 2019–20 MCP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, SCFHP submitted all required documentation and met all criteria for PIP modules that the MCP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on SCFHP's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

7. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[8] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

[8] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

8. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with SCFHP, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

9. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 9.1 provides EQR recommendations from SCFHP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 9.1 to preserve the accuracy of SCFHP's self-reported actions.

Table 9.1—SCFHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Identify the causes for the rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure moving to below the minimum performance level in reporting year 2018, and identify strategies to increase the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) receiving nephropathy screenings or monitoring tests.	The rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure may have moved below the minimum performance level in reporting year 2018 due to providers giving the urine dipstick test in the office but not necessarily coding and/or documenting the test correctly in the member's medical record. In working with our clinics, SCFHP found that clinics are attempting to outreach to members, but the phone numbers they have are incorrect. Additionally, when the clinics reach a member, most of the time the member does not show up for the appointment. To increase the percentage of diabetic beneficiaries receiving nephropathy screenings or monitoring tests, SCFHP launched a member incentive from October 15, 2018, through May 15, 2019, for targeted members. Additionally, SCFHP implemented a gap-in-care report for outbound calls to members; when members would contact SCFHP, they

2017–18 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	would be reminded to contact their PCP for a screening and offered assistance with making an appointment if needed. With this strategy in place, SCFHP increased its *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate above the minimum performance level for HEDIS 2019. However, the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure will no longer be required for reporting to DHCS for reporting year 2020. SCFHP will focus its efforts on improving rates for the new required measures.
2. Apply the lessons learned from the 2015–17 *Diabetes Retinal Eye Exam* and *Controlling High Blood Pressure* PIPs to facilitate improvement for future PIPs.	Lessons learned from the two PIPs SCFHP implemented in 2015–17 that would be beneficial for future PIPs include the following: ♦ Member incentives motivate our population. ♦ Increased communications with clinics helped to identify barriers earlier in the intervention process. ♦ Select measures that do not require a complete chart review if the MCP does not have direct electronic health record access to the clinic.

Assessment of MCP's Self-Reported Actions

HSAG reviewed SCFHP's self-reported actions in Table 9.1 and determined that SCFHP adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. SCFHP provided a summary of the potential causes for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate moving to below the minimum performance level in reporting year 2018 and indicated that the MCP's gap-in-care report and beneficiary incentive interventions resulted in the measure's rate improving to above the minimum performance level. Additionally, SCFHP provided a list of the lessons learned from the 2015–17 PIPs that may be beneficial for the MCP to apply to future PIPs.

2018–19 Recommendations

Based on the overall assessment of SCFHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to ensure that the MCP fully resolves all findings from the 2019 A&I State Supported Services audits.
- Identify the causes for the MCP's performance declining significantly from reporting year 2018 to reporting year 2019 for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure and develop strategies, as applicable, to address the significant decline in performance.

In the next annual review, HSAG will evaluate continued successes of SCFHP as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix EE:
Performance Evaluation Report
SCAN Health Plan
July 1, 2018–June 30, 2019

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Table of Tables

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted PSP, SCAN Health Plan ("SCAN" or "the PSP"). The purpose of this appendix is to provide PSP-specific results of each activity and an assessment of the PSP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this PSP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in SCAN's 2019–20 PSP-specific evaluation report. This PSP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Population-Specific Health Plan Overview

SCAN is a full-scope MCP delivering services to beneficiaries with specialized health care needs under the PSP model in Los Angeles, Riverside, and San Bernardino counties. Prior to the review period for this PSP-specific evaluation report, SCAN was designated as an SHP.

SCAN is a Medicare Advantage Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) that contracts with DHCS to provide services for the dual-eligible Medicare/Medi-Cal population subset residing in Los Angeles, Riverside, and San Bernardino counties. SCAN provides all services in the Medi-Cal State Plan, including home- and community-based services, to SCAN beneficiaries assessed at the nursing facility-level of care and in nursing home custodial care. SCAN beneficiaries must be at least 65 years of age, live in the service area, have Medicare Parts A and B, and have full-scope Medi-Cal with no share of cost. SCAN does not enroll individuals with end-stage renal disease.

SCAN has been licensed in California since November 30, 1984, in accordance with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, and became operational to provide MCMC services in Los Angeles County effective 1985. The PSP expanded into Riverside and San Bernardino counties in 1997.

In 2006, DHCS, at the direction of the Centers for Medicare & Medicaid Services (CMS), designated SCAN as an MCP. SCAN then functioned as a social health maintenance organization (HMO) under a federal waiver which expired at the end of 2007.

In 2008, SCAN entered a comprehensive risk contract with the State. SCAN receives monthly capitation from both Medicare and Medi-Cal, pooling its financing to pay for all services. DHCS amended SCAN's contract in 2008 to include the same federal and State requirements that exist for MCPs.

As of June 2019, SCAN had 9,037 beneficiaries in Los Angeles County, 2,502 beneficiaries in Riverside County, and 1,715 beneficiaries in San Bernardino County—for a total of 13,254 beneficiaries in the three counties combined.[1]

DHCS allows SCAN to combine data for Los Angeles, Riverside, and San Bernardino counties for reporting purposes. For this report, these three counties are considered a single reporting unit.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Population-Specific Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent review conducted for SCAN. The review description may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical Audit of SCAN. A&I conducted the audit from March 18, 2019, through March 22, 2019. DHCS issued the final closeout letter on November 19, 2019, which is outside the review period for this report; however, HSAG includes the information from the letter because it reflects full resolution of the findings from the March 2019 A&I Medical Audit.

Table 2.1—DHCS A&I Medical Audit of SCAN
Audit Review Period: March 1, 2018, through February 28, 2019

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	Yes	Corrective action plan (CAP) imposed and findings in this category rectified.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	Yes	CAP imposed and findings in this category rectified.
Administrative and Organizational Capacity	No	No findings.

Strengths—Compliance Reviews

A&I identified no deficiencies in the Utilization Management, Case Management and Coordination of Care, and Administrative and Organizational Capacity categories during the March 2019 Medical Audit of SCAN. Additionally, the information SCAN submitted to DHCS regarding the CAP for the findings in the Access and Availability of Care, Member's Rights, and Quality Management categories resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

SCAN has no outstanding findings from the March 2019 A&I Medical Audit; therefore, HSAG has no recommendations for the PSP in the area of compliance reviews.

3. Population-Specific Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®*[2] *2019 Compliance Audit Final Report of Findings for SCAN Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that SCAN followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results

After validating the PSP's performance measure rates, HSAG assessed the results. See Table 3.1 for SCAN's performance measure results for reporting years 2017 through 2019. The reporting year is the year in which the PSP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that data may not be available for all three years.

Note the following regarding Table 3.1:

- Due to changes that the National Committee for Quality Assurance (NCQA) made to the specifications for the *Colorectal Cancer Screening* and *Osteoporosis Management in Women Who Had a Fracture* measures in reporting year 2019, NCQA released guidance to exercise caution when trending the results for these measures. Therefore, caution should be used when comparing SCAN's performance across years or when comparing SCAN's results to benchmarks related to these measures, as differences in rates may be the result of specification changes rather than a reflection of performance.
- To assess performance for each PSP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires PSPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless PSPs are reporting the rates for the first time).
  - IPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For all reporting years displayed, the high performance levels and minimum performance levels for the *Colorectal Cancer Screening* measure represent the NCQA Quality Compass®[4] Commercial HMO 90th and 25th percentiles, respectively.
- For all reporting years displayed, the high performance levels and minimum performance levels for the *Osteoporosis Management in Women Who Had a Fracture* measure represent the NCQA Quality Compass® Medicaid HMO 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 8 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Population-Specific Health Plan Performance Measures").

Table 3.1—Multi-Year Performance Measure Results
SCAN—Los Angeles/Riverside/San Bernardino Counties

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

= Statistical testing result indicates that the reporting year 2019 rate is significantly better than the reporting year 2018 rate.

= Statistical testing result indicates that the reporting year 2019 rate is significantly worse than the reporting year 2018 rate.

Reporting year 2017 rates reflect measurement year data from January 1, 2016, through December 31, 2016.

Reporting year 2018 rates reflect measurement year data from January 1, 2017, through December 31, 2017.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

^ Caution should be exercised when assessing PSP performance for this measure given the changes that NCQA made to the specification for this measure for reporting year 2019.

— Indicates that the rate is not available.

Measure	Reporting Year 2017 Rate	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Years 2018–19 Rate Difference
Colorectal Cancer Screening^	73.24%	77.44%	76.69%	-0.75
Osteoporosis Management in Women Who Had a Fracture^	—	51.72%	53.70%	1.98

[4] Quality Compass® is a registered trademark of NCQA.

Performance Measure Findings

The rates for the *Colorectal Cancer Screening* and *Osteoporosis Management in Women Who Had a Fracture* measures showed no statistically significant changes from reporting year 2018 and reporting year 2019. The rates for both measures were between the high performance levels and minimum performance levels in reporting year 2019.

Strengths—Performance Measures

The HSAG auditor determined that SCAN followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Opportunities for Improvement—Performance Measures

Based on SCAN's reporting year 2019 performance measure results, HSAG has no recommendations for the PSP in the area of performance measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability. The following modules guide MCMC plans through this rapid-cycle PIP process:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes:
    - The topic rationale.
    - Comparative data supporting the need to improve the selected topic.
    - A list of the PIP team members, which consists of internal and external stakeholders.
    - A completed key driver diagram that defines the theory of change for improvement, including the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim and Global Aim.
- Module 2—SMART Aim Data Collection
  - MCMC plans define the SMART Aim measure and data collection methodology and develop the SMART Aim data run chart.
- Module 3—Intervention Determination
  - MCMC plans use process mapping and failure modes and effects analysis (FMEA) to identify potential interventions to test which may have direct effects on the SMART Aim.
- Module 4—Plan-Do-Study-Act (PDSA)
  - MCMC plans test and evaluate the interventions identified in Module 3 through a series of PDSA cycles.
- Module 5—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - Assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - Plan for sustained improvement.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with these plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3 and receive feedback on the intervention Plan portion of Module 4, the plans test interventions. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins to ensure the plans have addressed HSAG's feedback on the Plan portion of Module 4 and are making appropriate progress with intervention testing. Once MCMC plans complete testing an intervention, they determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), or whether the intervention was not successful and should be stopped (abandon).

In Module 5, MCMC plans summarize the overall PIP. When validating Module 5, HSAG assesses the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigns the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCMC plan accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCMC plan accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Performance Improvement Project Results and Findings

During the review period, SCAN conducted one Disparity PIP and one PSP-specific PIP. In this report, HSAG includes summaries of SCAN's Disparity and PSP-specific PIP module submissions as well as validation findings from the review period.

Disparity Performance Improvement Project

DHCS required SCAN to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own PSP-specific data, SCAN identified statin use among beneficiaries living with diabetes in San Bernardino County as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.1—SCAN *Statin Use in Persons with Diabetes* Disparity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of statin utilization among beneficiaries ages 40 to 75 diagnosed with diabetes and residing in San Bernardino County	77.02%	82.46%

Performance Improvement Project Validation Findings

During the review period of this report, HSAG validated Module 3 for the PSP's *Statin Use in Persons with Diabetes* Disparity PIP. Upon initial review of the module, HSAG determined that SCAN met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Supporting the sub-processes selection for the FMEA table.
- Including all required components of the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, SCAN incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the PSP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the PSP's *Statin Use in Persons with Diabetes* Disparity PIP, HSAG reviewed and provided feedback to SCAN on the Plan portion of the PDSA cycle for the intervention that the PSP selected to test. HSAG indicated to SCAN that the PSP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.2 presents a description of the intervention that SCAN tested for its *Statin Use in Persons with Diabetes* Disparity PIP. The table also indicates the key drivers that the intervention addressed.

Table 4.2—SCAN *Statin Use in Persons with Diabetes* Disparity PIP Intervention Testing

Intervention	Key Drivers Addressed
Conduct targeted outreach to both provider and beneficiary to provide the beneficiary's adherence history, appointment information, and medication.	♦ Frequency of prescriptions. ♦ Beneficiary engagement and compliance with a treatment plan for medication management and adherence. ♦ Beneficiary knowledge of medication and reason for the prescription.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to SCAN to discuss the progress of intervention testing and data collection/tracking related to the intervention evaluation and SMART Aim measure.

Although SCAN completed testing the intervention through the SMART Aim end date of June 30, 2019, the PSP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this PSP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in SCAN's 2019–20 PSP-specific evaluation report.

Cholesterol Medication Adherence Performance Improvement Project

SCAN selected cholesterol medication adherence for its 2017–19 SHP-specific PIP topic based on its SHP-specific data.

Table 4.3 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PIP.

Table 4.3—SCAN *Cholesterol Medication Adherence* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of statin medication adherence among beneficiaries ages 18 and older who are prescribed statin medications and assigned to Provider A[5]	80.26%	84.16%

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated Module 3 for the PSP's *Cholesterol Medication Adherence* PIP. Upon initial review of the module, HSAG determined that SCAN met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a step-by-step flow of the overall process in the process map.
- Supporting the sub-processes selection for the FMEA table.
- Including all required components of the FMEA table.
- Listing the appropriate potential interventions based on the ranked failure modes.
- Considering the reliability and sustainability of potential interventions.

After receiving technical assistance from HSAG, SCAN incorporated HSAG's feedback into Module 3. Upon HSAG's final review, HSAG determined that the PSP met all validation criteria for Module 3.

Intervention Testing

Prior to the intervention testing phase of the PSP's *Cholesterol Medication Adherence* PIP, HSAG reviewed and provided feedback to SCAN on the Plan portion of the PDSA cycle for the intervention that the PSP selected to test. HSAG indicated to SCAN that the PSP should incorporate HSAG's feedback prior to testing the intervention and contact HSAG upon encountering any issues throughout the PIP intervention testing phase.

Table 4.4 presents a description of the intervention that SCAN tested for its *Cholesterol Medication Adherence* PIP. The table also indicates the failure modes that the intervention addressed.

[5] Provider name removed for confidentiality.

Table 4.4—SCAN *Cholesterol Medication Adherence* PIP Intervention Testing

Intervention	Failure Modes Addressed
Conduct person-to-person telephonic outreach to assess barriers, provide education on medication adherence, and facilitate removing barriers as needed.	♦ Beneficiary not convinced of the importance and value of a 90-day medication supply. ♦ Beneficiary understands the 90-day supply benefit but cannot afford it. ♦ Beneficiary forgot about getting a refill on time. ♦ Beneficiary is not out of medication due to not taking the prescribed amount.

Throughout the intervention testing phase, HSAG sent periodic check-in email communications to SCAN to discuss the progress of intervention testing and data collection and tracking related to the intervention evaluation and SMART Aim measure.

Although SCAN completed testing the intervention through the SMART Aim end date of June 30, 2019, the PSP did not progress to submitting modules 4 and 5 to HSAG for validation during the review period for this PSP-specific evaluation report. Therefore, HSAG includes no outcomes information in this report. HSAG will include a summary of the PIP outcomes in SCAN's 2019–20 PSP-specific evaluation report.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, SCAN submitted all required documentation and met all criteria for PIP modules that the PSP completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

Based on SCAN's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Consumer Surveys

DHCS periodically evaluates the perceptions and experiences of beneficiaries as part of its process for assessing the quality of health care services. For full-scope MCPs that are not PSPs, DHCS contracted with HSAG during the July 1, 2018, through June 30, 2019, reporting period to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[6] survey instruments.

PSPs are not included in the CAHPS surveys that HSAG conducts and are instead required to administer their own annual consumer satisfaction surveys to evaluate beneficiary satisfaction regarding care and services provided.

While HSAG reviewed the information submitted by SCAN to DHCS for the most recent consumer survey conducted for the PSP, the purpose of HSAG's review was to confirm the PSP conducted the survey as required, not to analyze the survey results or identify opportunities for improvement. The following is a brief summary of the consumer survey conducted for SCAN, including the notable high-level results.

Consumer Surveys Conducted for SCAN

SCAN uses the Group Level Survey (GLS) instrument for the assessment of beneficiary satisfaction at the SCAN physician and network levels. SCAN's annual GLS is a 59-question tool that includes CAHPS, Health Outcomes Survey, and additional questions that are used to achieve the following objectives:

- Measure patient satisfaction with SCAN networks.
- Analyze performance by network.
- Determine key drivers of patients' overall ratings of SCAN doctors.
- Provide direction to improve the quality of care provided by SCAN physicians and networks.

In 2018, SCAN contracted with Decision Support Systems (DSS) Research to administer the survey.

[6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Results—Consumer Surveys

DSS Research indicated that results show that doctor-patient communication was the driver of the overall ratings of SCAN doctors and the health care received.

For both the overall rating of the doctor and overall rating of health care, the following were identified as the most important strengths driving the ratings:

- The doctor:
  - Listened carefully.
  - Showed respect for what the patient had to say.
  - Explained things in a way that was easy to understand.
  - Spent enough time with the patient.

The areas that were identified as having the most potential to increase the overall doctor rating were for doctors to:

- Speak with patients about their prescriptions.
- Follow up with test results.

The areas that were identified as having the most potential to improve the overall rating of health care were to increase the availability of:

- Specialists.
- Appointments for routine care.

6. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study with SCAN, which consisted of medical record review. The *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report* contains HSAG's detailed findings and recommendations from the EDV study. Within the *State Fiscal Year (SFY) 2018–19 Encounter Data Validation Study Aggregate Report*, HSAG presented MCP-, PSP-, and SHP-specific results; however, HSAG provided no detailed conclusions regarding MCP-, PSP-, and SHP-specific results. Section 15 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Encounter Data Validation") provides a summary of the aggregated results and conclusions from the EDV study and, as applicable, comparisons of findings across MCPs, PSPs, and SHPs.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 7.1 provides EQR recommendations from SCAN's July 1, 2017, through June 30, 2018, PSP-specific evaluation report, along with the PSP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of SCAN's self-reported actions.

Table 7.1—SCAN's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, PSP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to SCAN	Self-Reported Actions Taken by SCAN during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Continue monitoring adopted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2015–17 *Diabetes Medication Adherence* and *Statin Use in Persons with Diabetes* PIPs.	We continued to monitor interventions and applied improvements. Implementation of member and provider interventions to educate both members and providers on the benefits of statin use in persons with diabetes included: ♦ Clinical staff conducted high-touch targeted telephonic outreach to discuss therapy regimen (education) with the physician and member. ♦ Created an incentive program for physician offices to encourage office staff to schedule appointments with members and encourage physicians to prescribe statins.
2. Apply lessons learned from the 2015–17 *Statin Use in Persons with Diabetes* PIP to the PSP's 2017–19 *Statin Use in Persons with Diabetes* Disparity PIP.	Based on previous lessons learned, we applied the following process improvements: ♦ Implemented additional clinical resources for education. ♦ Improved reporting systems at the member level for monthly and emergent reporting. ♦ Deployed technological solutions to better track results and trends.

Assessment of PSP's Self-Reported Actions

HSAG reviewed SCAN's self-reported actions in Table 7.1 and determined that SCAN adequately addressed HSAG's recommendations from the PSP's July 1, 2017, through June 30, 2018, PSP-specific evaluation report. SCAN described how the PSP continued monitoring adopted interventions and outcomes from the 2015–17 *Diabetes Medication Adherence* and *Statin Use in Persons with Diabetes* PIPs. Additionally, SCAN described process improvements the PSP made based on lessons learned from the 2015–17 *Statin Use in Persons with Diabetes* PIP.

2018–19 Recommendations

Based on the overall assessment of SCAN's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the PSP.

In the next annual review, HSAG will evaluate SCAN's continued successes.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix FF:
Performance Evaluation Report
UnitedHealthcare Community Plan
July 1, 2018–June 30, 2019

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§) 438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care (MCMC) program, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Two of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one contracted MCO and one prepaid inpatient health plan (PIHP) with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the MCO and the PIHP with specialized populations as SHPs. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, UnitedHealthcare Community Plan ("UHC" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to, health care services furnished to MCMC beneficiaries (referred to as "beneficiaries" in this report). The review period for this MCP-specific evaluation report is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond the review period in UHC's 2019–20 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail by HSAG in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to, health care that MCMC plans are providing to beneficiaries.

Medi-Cal Managed Care Health Plan Overview

UHC is a full-scope MCP delivering services to beneficiaries under a Geographic Managed Care (GMC) model. The GMC model is currently available in San Diego and Sacramento counties. Under this particular GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

UHC became operational in Sacramento County to provide services effective October 1, 2017; however, the MCP stopped providing MCMC services in Sacramento County effective October 31, 2018. HSAG provides no results or analyses in this MCP-specific report related to services the MCP provided in this county.

UHC became operational in San Diego County to provide MCMC services effective October 1, 2017. As of June 2019, UHC had 10,870 beneficiaries,[1] which represents 2 percent of the beneficiaries enrolled in San Diego County.

In addition to UHC, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Shield of California Promise Health Plan (known as Care1st Partner Plan prior to January 1, 2019)
- Community Health Group Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser SoCal
- Molina Healthcare of California Partner Plan, Inc.

[1] *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

2. Managed Care Health Plan Compliance

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for UHC. The descriptions of the two types of reviews may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of UHC. A&I conducted the audits from May 28, 2019, through June 7, 2019. DHCS issued the audit reports to UHC on October 18, 2019, which is outside the review period for this report; however, HSAG includes the information from the reports because they were available prior to HSAG producing this MCP-specific evaluation report.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of UHC
Audit Review Period: April 1, 2018, through April 30, 2019

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	Corrective action plan (CAP) in process and under review.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	Yes	CAP in process and under review.
State Supported Services	Yes	CAP in process and under review.

Strengths—Compliance Reviews

A&I identified no findings in the Case Management and Coordination of Care category during the May 28, 2019, through June 7, 2019, Medical and State Supported Services Audits of UHC.

Opportunities for Improvement—Compliance Reviews

UHC has the opportunity to work with DHCS to ensure that the MCP fully resolves all findings from the May 28, 2019, through June 7, 2019, Medical and State Supported Services Audits. The findings cut across the areas of quality and timeliness of, and access to, health care.

3. Managed Care Health Plan Performance Measures

Performance Measure Validation Results

The *HEDIS®[2] 2019 Compliance Audit Final Report of Findings for UnitedHealthcare Community Plan* contains the detailed findings and recommendations from HSAG's HEDIS Compliance Audit™.[3] The HSAG auditor determined that UHC followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for UHC's performance measure results for reporting year 2019. The reporting year is the year in which the MCP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year.

Note the following regarding Table 3.1 through Table 3.4

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects. Table 3.1 through Table 3.4 present the performance measure results and findings by domain.
- To assess performance for each MCP reporting unit, HSAG compares the rates to national benchmarks. Rates indicating performance above the high performance levels are shaded in gray, and rates indicating performance below the minimum performance levels are bolded.
  - For measures with rates below the minimum performance levels, DHCS requires MCPs to submit to DHCS improvement plans (IPs) to address the rates below the minimum performance levels (unless MCPs are reporting the rates for the first time).
  - For MCPs that meet DHCS' Quality of Care CAP thresholds, DHCS issues a CAP. If an MCP's performance is such that it may trigger a CAP in the following year, DHCS issues an advance warning letter.
  - IPs and CAPs consist of submission of Plan-Do-Study-Act (PDSA) Cycle Worksheets or completion of performance improvement projects (PIPs)—as determined by DHCS.

[2] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

- For reporting year 2019, the high performance levels and minimum performance levels represent the NCQA Quality Compass®[4] Medicaid health maintenance organization (HMO) 90th and 25th percentiles, respectively.
- HSAG includes the specific high performance level and minimum performance level values for reporting year 2019 in Section 7 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Managed Care Health Plan Performance Measures").

Note the following regarding UHC's performance measure results:

- Reporting year 2019 was the first year UHC reported performance measure rates; therefore:
  - DHCS did not hold the MCP accountable to meet minimum performance levels (i.e., DHCS did not require UHC to submit IPs for measures with rates below the minimum performance levels). As applicable, the performance measure results tables denote instances of rates below the minimum performance levels to help DHCS and UHC identify potential opportunities for improvement regarding measures for which DHCS will hold the MCP accountable to meet minimum performance levels for reporting year 2020.
  - HSAG presents no findings and makes no recommendations related to the MCP's reporting year 2019 performance measure results.

Preventive Screening and Children's Health

Table 3.1 presents reporting year 2019 results for the performance measures within the Preventive Screening and Children's Health domain.

Table 3.1—Preventive Screening and Children's Health Domain
Reporting Year 2019 Performance Measure Results
UHC—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

[4] Quality Compass® is a registered trademark of NCQA.

Measure	Reporting Year 2019 Rate
Childhood Immunization Status—Combination 3	NA
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	**85.29%**
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	**71.08%**
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA
Immunizations for Adolescents—Combination 2	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	68.14%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	64.60%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**59.15%**

Preventive Screening and Women's Health

Table 3.2 presents the reporting year 2019 results for the performance measures within the Preventive Screening and Women's Health domain.

Table 3.2—Preventive Screening and Women's Health Domain
Reporting Year 2019 Performance Measure Results
UHC—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Measure	Reporting Year 2019 Rate
Breast Cancer Screening	NA
Cervical Cancer Screening	**45.99%**
Prenatal and Postpartum Care—Postpartum Care	**56.52%**
Prenatal and Postpartum Care—Timeliness of Prenatal Care	**75.36%**

Care for Chronic Conditions

Table 3.3 presents the reporting year 2019 results for the performance measures within the Care for Chronic Conditions domain.

Table 3.3—Care for Chronic Conditions Domain
Reporting Year 2019 Performance Measure Results
UHC—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

* A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Measure	Reporting Year 2019 Rate
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	92.42%
Annual Monitoring for Patients on Persistent Medications—Diuretics	**80.00%**
Asthma Medication Ratio	NA
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	72.13%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.46%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	**39.34%**
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)**	**47.54%**
Comprehensive Diabetes Care—HbA1c Testing	86.89%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	96.72%
Controlling High Blood Pressure	64.44%

Appropriate Treatment and Utilization

Table 3.4 presents the reporting year 2019 results for the performance measures within the Appropriate Treatment and Utilization domain.

Table 3.4—Appropriate Treatment and Utilization Domain
Reporting Year 2019 Performance Measure Results
UHC—San Diego County

= Rate indicates performance above the high performance level.

Bolded Rate = Rate indicates performance below the minimum performance level.

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = The MCP's measure is publicly reported based on NCQA HEDIS Compliance Audit results; however, since fewer than 11 cases exist in the numerator of this measure, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a reporting year 2018 or reporting year 2019 rate is suppressed, HSAG also suppresses the reporting year 2018–19 rate difference.

Measure	Reporting Year 2019 Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	38.33
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	230.08
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	NA
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening	S
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen	NA
*Plan All-Cause Readmissions***	NA
Use of Imaging Studies for Low Back Pain	NA

Seniors and Persons with Disabilities Performance Measure Results

Table 3.5 presents the reporting year 2019 results for the Seniors and Persons with Disabilities (SPD) population, and Table 3.6 presents the reporting year 2019 results for the non-SPD population for the measures that DHCS required MCPs to stratify for the SPD and non-SPD populations. Reporting year 2019 was the first year UHC reported performance measure rates stratified by the SPD and non-SPD populations; therefore, HSAG presents no analyses within Table 3.5 and Table 3.6.

HSAG calculated no SPD/non-SPD rate differences. For the *Ambulatory Care* measures, high and low rates do not necessarily indicate better or worse performance. For all other measures stratified by the SPD and non-SPD populations, HSAG was unable to make a comparison between the reporting year 2019 SPD and non-SPD rates due to all SPD rates having denominators too low for UHC to report valid rates.

Table 3.5—Reporting Year 2019 SPD Performance Measure Results UHC—San Diego County

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Measure	Reporting Year 2019 SPD Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	53.72
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	336.73
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	NA
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	NA

Measure	Reporting Year 2019 SPD Rate
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA
*Plan All-Cause Readmissions***	NA

Table 3.6—Reporting Year 2019 Non-SPD Performance Measure Results UHC—San Diego County

Reporting year 2019 rates reflect measurement year data from January 1, 2018, through December 31, 2018.

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Measure	Reporting Year 2019 Non-SPD Rate
*Ambulatory Care—Emergency Department Visits per 1,000 Member Months**	37.43
*Ambulatory Care—Outpatient Visits per 1,000 Member Months**	223.85
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	94.12%
Annual Monitoring for Patients on Persistent Medications—Diuretics	NA
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	85.29%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	70.89%

Measure	Reporting Year 2019 Non-SPD Rate
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	NA
*Plan All-Cause Readmissions***	NA

Strengths—Performance Measures

The HSAG auditor determined that UHC followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

The rate for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure was above the high performance level in reporting year 2019.

Opportunities for Improvement—Performance Measures

Reporting year 2019 was the first year UHC reported performance measure rates; therefore, HSAG identified no opportunities for the MCP in the area of performance measures.

4. Performance Improvement Projects

DHCS requires that each MCP, PSP, and SHP conduct a minimum of two DHCS-approved performance improvement projects (PIPs) per each Medi-Cal contract held with DHCS. If an MCP, PSP, or SHP holds multiple contracts with DHCS and the areas in need of improvement are similar across contracts, DHCS may approve the MCP, PSP, or SHP to conduct the same two PIPs across all contracts (i.e., conduct a total of two PIPs).

Based on UHC providing services starting October 1, 2017, DHCS waived the requirement for the MCP to conduct PIPs during the review period for this MCP-specific evaluation report. In April 2019, HSAG began to provide trainings and technical assistance to UHC on the PIP process and requirements so that the MCP will be prepared to conduct PIPs starting in July 2019.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an annual timely access focused study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels. Section 13 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS provided quarterly MCP-level reports and raw data to each MCP and required the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviewed and provided feedback to each MCP and then determined whether or not the MCP is required to take further action. DHCS also used the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data.

6. Consumer Surveys

During the July 1, 2018, through June 30, 2019, review period, HSAG administered the following standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[5] survey instruments:

- CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set for the CHIP population.
- CAHPS 5.0 Adult Medicaid Health Plan Surveys for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.
- CAHPS 5.0 Child Medicaid Health Plan Surveys without the CCC measurement set for 25 MCPs at the parent unit-level, with county-level oversampling where appropriate.

Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019* ("Consumer Surveys") provides aggregated results and conclusions for all 25 MCPs. While HSAG included MCP-specific results in the *2018–19 Medicaid Managed Care CAHPS Survey Summary Report*, HSAG did not analyze the survey results at the MCP or reporting unit level; thus, HSAG includes no MCP-specific CAHPS survey results, strengths, or opportunities for improvement in this MCP-specific evaluation report.

[5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

7. Encounter Data Validation

During the review period of July 1, 2018, through June 30, 2019, HSAG conducted an encounter data validation (EDV) study to evaluate MCMC encounter data completeness and accuracy via a review of medical records for physician services rendered between January 1, 2017, and December 31, 2017. UHC began serving Medi-Cal beneficiaries in October 2017 and did not have a full year's worth of encounter data; therefore, UHC was not included in the 2018–19 EDV study.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP and SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2017–18 MCP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from UHC's July 1, 2017, through June 30, 2018, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2019, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of UHC's self-reported actions.

Table 8.1—UHC's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2017, through June 30, 2018, MCP-Specific Evaluation Report

2017–18 External Quality Review Recommendations Directed to UHC	Self-Reported Actions Taken by UHC during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
1. Work with DHCS and HSAG to ensure that the MCP fully understands all EQRO activities and DHCS' requirements of the MCP related to each activity.	UHC's California chief medical officer and director of clinical quality met with the DHCS Managed Care Quality and Monitoring Division (MCQMD) quality improvement staff twice in 2018. The MCP shared current progress in the External Accountability Set (EAS) measures, challenges to success, and the 2019 strategic plans. UHC attended the DHCS Quality Improvement Orientation session hosted by MCQMD in 2018. UHC served as a pilot MCP for which the contents of the quality improvement session were reviewed and discussed prior to delivering to all MCMC plans. UHC also received and reviewed the Quality Improvement Toolkit housed by MCQMD on a secure Microsoft SharePoint site. UHC has integrated best practices into the MCP's 2019 Strategic Plan.

2017–18 External Quality Review Recommendations Directed to UHC	Self-Reported Actions Taken by UHC during the Period of July 1, 2018–June 30, 2019, that Address the External Quality Review Recommendations
	Although not required in year one following implementation, UHC has developed several quality improvement studies to target low-scoring Managed Care Accountability Set (MCAS) measures. One study includes an effectiveness analysis of an intervention to mail members with care gaps custom preventive letters. UHC has integrated all applicable MCAS measures into HEDIS reporting logic and is currently able to monitor and track performance. The MCP was also able to adjust the minimum performance level to the 50th percentile and is tracking performance against the new benchmark. UHC successfully submitted HEDIS data to NCQA before the deadline and met the minimum performance level for nine (50 percent) of the 18 EAS measures reported.

Assessment of MCP's Self-Reported Actions

HSAG reviewed UHC's self-reported actions in Table 8.1 and determined that UHC adequately addressed HSAG's recommendations from the MCP's July 1, 2017, through June 30, 2018, MCP-specific evaluation report. UHC described in detail actions taken during the review period to ensure full understanding of all EQRO activities and DHCS' requirements of the MCP related to each activity. UHC also described actions taken above and beyond DHCS' recommendations to improve quality of care for the MCP's beneficiaries.

2018–19 Recommendations

Based on the overall assessment of UHC's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that UHC work with DHCS to ensure that the MCP fully resolves all findings from the May 28, 2019, through June 7, 2019, Medical and State Supported Services Audits.

In the next annual review, HSAG will evaluate continued successes of UHC as well as the MCP's progress with the recommendation.