Volume 2 of 6

Medi-Cal Managed Care External Quality Review Technical Report

July 1, 2022–June 30, 2023

Medi-Cal Managed Care
Plan-Specific Information

Quality and Population Health Management
California Department of Health Care Services

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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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Medi-Cal Managed Care Plan Name Abbreviations

Health Services Advisory Group, Inc. (HSAG) uses the following abbreviated Medi-Cal Managed Care (MCMC) plan names in this volume.

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

Commonly Used Abbreviations and Acronyms

- **A&I**—Audits & Investigations Division
- **ADA**—Americans with Disabilities Act
- **ADHD**—Attention-Deficit Hyperactivity Disorder
- **APL**—All Plan Letter
- **BHT**—behavioral health treatment
- **BMI**—body mass index
- **CAP**—corrective action plan
- **CCS**—California Children Services
- **CFR**—Code of Federal Regulations
- **CIN**—client identification number
- **CMS**—Centers for Medicare & Medicaid Services
- **COVID-19**—coronavirus disease 2019
- **CPT**—Current Procedural Terminology
- **DBA**—doing business as
- **DHCS**—California Department of Health Care Services
- **DMHC**—Department of Managed Health Care
- **EDGE**—Evaluating Data to Generate Excellence
- **EHR**—electronic health record
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **FAQ**—frequently asked questions
- **FMEA**—failure modes and effects analysis
- **FQHC**—federally qualified health center
- **G&A**—Grievances & Appeals
- **HbA1c**—Hemoglobin A1c
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[1]
- **HIV**—human immunodeficiency virus
- **HMO**—health maintenance organization
- **HPV**—human papillomavirus
- **HRA**—health risk assessment
- **HSAG**—Health Services Advisory Group, Inc.
- **IHA**—initial health assessment

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

- **IPA**—independent physician association
- **IVR**—interactive voice response
- **MCAS**—Managed Care Accountability Set
- **MCMC**—Medi-Cal Managed Care program
- **MCP**—managed care health plan
- **MERP**—member engagement and rewards program
- **MOU**—memorandum of understanding
- **NCQA**—National Committee for Quality Assurance
- **NEMT**—non-emergency medical transportation
- **NMT**—nonmedical transportation
- **NOA**—Notice of Action
- **OB/GYN**—obstetrician/gynecologist
- **P4P**—pay-for-performance
- **PCP**—primary care provider
- **PCS**—Physician Certification Statement
- **PDSA**—Plan-Do-Study-Act
- **PHI**—Protected Health Information
- **PIP**—performance improvement project
- **PNF**—Pregnancy Notification Form
- **PQI**—potential quality issue
- **PSP**—population-specific health plan
- **QOC**—quality of care
- **QR**—quick response
- **Roadmap**—HEDIS Record of Administration, Data Management, and Processes
- **SMART**—Specific, Measurable, Achievable, Relevant, and Time-bound
- **STI**—sexually transmitted infection
- **SWOT**—Strengths, Weaknesses, Opportunities, Threats

Introduction

The 2022–23 Medi-Cal Managed Care External Quality Review Technical Report is an annual, independent, technical report produced by Health Services Advisory Group, Inc. (HSAG), the external quality review organization (EQRO) for the California Department of Health Care Services' (DHCS') Medi-Cal Managed Care program (MCMC). The purpose of this report is to provide a summary of the external quality review (EQR) activities of DHCS' contracted Medi-Cal managed care health plans (MCPs) and population-specific health plans (PSPs). This report will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This Volume 2 of the *2022–23 Medi-Cal Managed Care External Quality Review Technical Report* includes the following MCMC plan-specific information:

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

Note that the statewide aggregate assessment of MCMC for the federally mandated and optional EQR activities is included in Volume 1; MCMC plan-specific compliance review results are included in Volume 3; and comparative MCP performance measure results are included in Volume 4.

The review period for this report is July 1, 2022, through June 30, 2023. HSAG will report on activities that take place beyond this report's review period in the *2023–24 Medi-Cal Managed Care External Quality Review Technical Report*.

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

This appendix provides performance measure results for the two PSPs, AIDS Healthcare Foundation (AHF) and SCAN Health Plan (SCAN). These two PSPs provide services to specialized populations; therefore, DHCS' performance measure requirements for them are different than its requirements for MCPs. Due to each PSP serving a specialized population, HSAG, produces no aggregate information related to the PSP performance measures. Also, due to the PSPs serving separate, specialized populations, performance measure comparison across PSPs is not appropriate.

Table A.1 and Table A.2 provide performance measure results for measurement years 2020, 2021, and 2022 for AHF and SCAN, respectively.

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

- High performance levels and minimum performance levels represent the 2022 National Committee for Quality Assurance (NCQA) Quality Compass®,[2] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively.
- Based on DHCS' performance measure requirements, HSAG compares rates for the *Controlling High Blood Pressure—Total* measure to the high performance levels and minimum performance levels for measurement years 2021 and 2022 only.

Please refer to Table 5.1 and Table 5.2 in Section 5 of *Volume 1 of 6* of this report ("Managed Care Health Plan Performance Measures") for the descriptions of all performance measures and the benchmarks HSAG used for high performance level and minimum performance level comparisons included in the applicable tables.

Table A.1—Measurement Years 2020, 2021, and 2022 Performance Measure Results AHF—Los Angeles County

= Rate indicates performance at or better than the high performance level.

Bolded Rate = Rate indicates performance worse than the minimum performance level.

= Statistical testing result indicates that the measurement year 2022 rate is significantly better than the measurement year 2021 rate.

= Statistical testing result indicates that the measurement year 2022 rate is significantly worse than the measurement year 2021 rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

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

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

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

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

— Indicates that the rate is not available.

* For this measure, only the measurement years 2021 and 2022 rates are compared to the high performance levels and minimum performance levels based on DHCS' performance measure requirements.

** For this measure, only the measurement year 2022 rate is compared to the high performance level and minimum performance level based on DHCS' performance measure requirements.

^ A lower rate indicates better performance for this measure.

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

Not Comparable = A measurement year 2021–22 rate difference cannot be calculated because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Measures Held to Minimum Performance Levels				
*Controlling High Blood Pressure—Total**	69.70%	63.56%	71.82%	8.26
*Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—18 Years and Older***	—	NA	NA	Not Comparable
*Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—18 Years and Older***	—	NA	NA	Not Comparable
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)^*	22.00%	26.15%	26.32%	0.17

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Report Only Measures				
Adults' Access to Preventive/Ambulatory Health Services—Total	—	—	91.98%	Not Comparable
Colorectal Cancer Screening	—	—	42.63%	Not Comparable
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	NA	NA	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Follow-up PHQ-9—Ages 18–44 Years	—	—	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Follow-up PHQ-9—Ages 45–64 Years	—	—	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Follow-up PHQ-9—65 Years and Older	—	—	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Follow-up PHQ-9—Total	—	—	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Depression Remission—Ages 18–44 Years	—	—	NA	Not Comparable

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Depression Remission or Response for Adolescents and Adults—Depression Remission— Ages 45–64 Years	—	—	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Depression Remission— 65 Years and Older	—	—	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Depression Remission—Total	—	—	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Depression Response— Ages 18–44 Years	—	—	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Depression Response— Ages 45–64 Years	—	—	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Depression Response— 65 Years and Older	—	—	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Depression Response—Total	—	—	NA	Not Comparable

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening— Ages 18–64 Years	—	—	30.04%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening— 65 Years and Older	—	—	NA	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—Total	—	—	30.36%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen— Ages 18–64 Years	—	—	NA	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen— 65 Years and Older	—	—	NA	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—Total	—	—	NA	Not Comparable
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up— 18 Years and Older	—	NA	NA	Not Comparable

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up— 18 Years and Older	—	NA	NA	Not Comparable
Pharmacotherapy for Opioid Use Disorder	—	—	NA	Not Comparable

Note that Table A.2 includes SCAN's performance measure results for Los Angeles, Riverside, and San Bernadino counties only. To report performance measure rates, a plan's members must meet continuous enrollment requirements for each measure that the plan is reporting, which means that members need to be enrolled in the plan for 11 of 12 months during the measurement year. SCAN began providing MCMC services in San Diego County on January 1, 2023; therefore, no SCAN members residing in San Diego County met the continuous enrollment requirements during measurement years 2020, 2021, and 2022. SCAN's performance measure rates will include San Diego County beginning with measurement year 2023, and HSAG will include those results in the 2023–24 EQR technical report.

Table A.2—Measurement Years 2020, 2021, and 2022 Performance Measure Results SCAN—Los Angeles/Riverside/San Bernardino Counties

= Rate indicates performance at or better than the high performance level.

Bolded Rate = Rate indicates performance worse than the minimum performance level.

= Statistical testing result indicates that the measurement year 2022 rate is significantly better than the measurement year 2021 rate.

= Statistical testing result indicates that the measurement year 2022 rate is significantly worse than the measurement year 2021 rate.

Measurement year 2020 rates reflect data from January 1, 2020, through December 31, 2020.

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

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

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

* For this measure, only the measurement years 2021 and 2022 rates are compared to the high performance levels and minimum performance levels based on DHCS' performance measure requirements.

** For this measure, only the measurement year 2022 rate is compared to the high performance level and minimum performance level based on DHCS' performance measure requirements.

^ A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A measurement year 2021–22 rate difference cannot be calculated because data are not available for both years.

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Measures Held to Minimum Performance Levels				
Breast Cancer Screening—Total	77.35%	77.09%	79.62%	2.53
*Controlling High Blood Pressure—Total**	66.42%	68.46%	73.61%	5.15
*Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—65 Years and Older***	—	NA	NA	Not Comparable
*Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—65 Years and Older***	—	NA	NA	Not Comparable
*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)^*	20.55%	17.53%	13.60%	-3.93
Report Only Measures				
Adults' Access to Preventive/Ambulatory Health Services—Total	—	—	95.18%	Not Comparable
Colorectal Cancer Screening	—	—	73.26%	Not Comparable

Measure	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Years 2021–22 Rate Difference
Depression Remission or Response for Adolescents and Adults—Follow-up PHQ-9—65 Years and Older	—	—	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Depression Remission—65 Years and Older	—	—	NA	Not Comparable
Depression Remission or Response for Adolescents and Adults—Depression Response—65 Years and Older	—	—	NA	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—65 Years and Older	—	—	0.00%	Not Comparable
Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—65 Years and Older	—	—	NA	Not Comparable
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—65 Years and Older	—	NA	NA	Not Comparable
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—65 Years and Older	—	NA	NA	Not Comparable
Pharmacotherapy for Use Opioid Disorder	—	—	NA	Not Comparable

Appendix B. Comparative MCMC Plan-Specific Performance Improvement Project Information

This appendix provides the module validation criteria and confidence level definitions for HSAG's rapid-cycle PIP process that HSAG used for validating MCMC plans' 2020–22 PIPs. Additionally, this appendix includes MCMC plan-specific PIP topics and validation findings, as well as descriptions of interventions MCMC plans tested and outcomes achieved during the review period of July 1, 2022, through June 30, 2023.

Module Validation Criteria

HSAG conducts PIP validation in accordance with the Centers for Medicare & Medicaid Services (CMS) *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*.[3] Following are the validation criteria that HSAG uses for each module:

Module 1—PIP Initiation

- The MCMC plan provided the description and rationale for the selected narrowed focus, and the reported baseline data support an opportunity for improvement.
- The narrowed focus baseline specifications and data collection methodology supported the rapid-cycle process and included the following:
  - Complete and accurate specifications.
  - Data source(s).
  - Step-by-step data collection process.
  - Narrowed focus baseline data that considered claims data completeness.
- The SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim was stated accurately and included all required components (i.e., narrowed focus, intervention[s], baseline percentage, goal percentage, and end date).

[3] Note that for the 2020–22 PIPs, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Sep 18, 2023. Beginning with the 2023–26 PIPs, HSAG will use *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 4, 2024.

- The SMART Aim run chart included all required components (i.e., run chart title, Y-axis title, SMART Aim goal percentage line, narrowed focus baseline percentage line, and X-axis months).
- The MCMC plan completed the attestation and confirmed the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.
- The MCMC plan accurately completed all required components of the key driver diagram. The drivers and interventions were logically linked and have the potential to impact the SMART Aim goal.

Module 2—Intervention Determination

- The MCMC plan included a process map that clearly illustrated the step-by-step flow of the current processes for the narrowed focus.
- The prioritized steps in the process map identified as gaps or opportunities for improvement were clearly labeled.
- The steps documented in the failure modes and effects analysis (FMEA) table aligned with the steps in the process map that were identified as gaps or opportunities for improvement.
- The failure modes, failure causes, and failure effects were logically linked to the steps in the FMEA table.
- The MCMC plan prioritized the listed failure modes and ranked them from highest to lowest in the failure mode priority ranking table.
- The key drivers and interventions in the key driver diagram were updated according to the results of the corresponding process map and FMEA. In the key driver diagram, the MCMC plan included interventions that were culturally and linguistically appropriate and have the potential for impacting the SMART Aim goal.

Module 3—Intervention Testing

- The intervention plan included at least one corresponding key driver and one failure mode from Module 2.
- The MCMC plan included all components for the intervention plan.
- The intervention effectiveness measure(s) was appropriate for the intervention.
- The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.

Module 4—PIP Conclusions

- The rolling 12-month data collection methodology was followed for the SMART Aim measure for the duration of the PIP.
- The MCMC plan provided evidence to demonstrate at least one of the following:

  - The SMART Aim goal was achieved.
  - Statistically significant improvement over the narrowed focus baseline percentage was achieved (95 percent confidence level, $p < 0.05$).
  - Non-statistically significant improvement in the SMART Aim measure.
  - Significant clinical improvement in processes and outcomes.
  - Significant programmatic improvement in processes and outcomes.
- If improvement was demonstrated, at least one of the tested interventions could reasonably result in the demonstrated improvement.
- The MCMC plan completed the Plan-Do-Study-Act (PDSA) worksheet(s) with accurately reported data and interpretation of testing results.
- The narrative summary of the project conclusions was complete and accurate.
- If improvement was demonstrated, the MCMC plan documented plans for sustaining improvement beyond the SMART Aim end date.

Confidence Level Definitions

Once a PIP reaches completion, HSAG assesses the validity and reliability of the results to determine whether key stakeholders may have confidence in the reported PIP findings. HSAG assigns the following confidence levels for each PIP:

- High confidence
  - The PIP was methodologically sound.
  - The MCMC plan achieved the SMART Aim goal or achieved statistically significant, clinically significant, or programmatically significant improvement.
  - At least one of the tested interventions could reasonably result in the demonstrated improvement.
  - The MCMC plan accurately summarized the key findings and conclusions.
- Moderate confidence
  - The PIP was methodologically sound.
  - At least one of the tested interventions could reasonably result in the demonstrated improvement.
  - One of the following occurred:
    - Non-statistically significant improvement in the SMART Aim measure was achieved, with no evidence of statistically significant, clinically significant, or programmatically significant improvement; and the MCMC plan accurately summarized the key findings and conclusions.
    - The MCMC plan achieved the SMART Aim goal or achieved statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement; however, the MCMC plan did not accurately summarize the key findings and conclusions.

- Low confidence
  - The PIP was methodologically sound.
  - One of the following occurred:
    - No improvement was achieved.
    - The MCMC plan achieved the SMART Aim goal or achieved statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement; however, none of the tested interventions could reasonably result in the demonstrated improvement.
- No confidence
  - The SMART Aim measure and/or approved rapid-cycle PIP methodology was not followed through the SMART Aim end date.

Performance Improvement Project Validation Findings

During the review period of this *2022–23 Medi-Cal Managed Care External Quality Review Technical Report*, all MCMC plans continued to test interventions for their 2020–22 PIPs through the SMART Aim end date of December 31, 2022. In April, May, and June 2023, the MCMC plans submitted their final Module 4s to HSAG for validation. In May and June 2023, HSAG validated Module 4 submissions and assigned final PIP confidence levels for all MCMC plans' 2020–22 PIPs.

Table B.1 lists MCMC plans' 2020–22 PIP topics and the final confidence levels HSAG assigned to the PIPs as part of the validation process.

Table B.1—Medi-Cal Managed Care Health Plan 2020–22 Performance Improvement Project Topics and Final Confidence Levels

*The MCMC plan did not have enough data to demonstrate an identified health disparity; therefore, DHCS waived the requirement for the MCMC plan to conduct a PIP on a health disparity.

^The MCMC plan does not serve the child or adolescent population; therefore, DHCS waived the requirement for the MCMC plan to conduct a PIP on child and adolescent health.

MCMC Plan Name	PIP Topic	Final Confidence Level
Managed Care Health Plans		
AAH	*Breast Cancer Screening Among African Americans* (Health Equity PIP)	High Confidence
	Child and Adolescent Well-Care Visits (Ages 3 to 21)	Low Confidence
Aetna*	*Diabetes Control*	High Confidence
	Well-Child Visits (Ages 3 to 11)	No Confidence
Anthem Blue Cross	*Cervical Cancer Screening Among Vietnamese Members* (Health Equity PIP)	High Confidence
	Childhood Immunizations	Low Confidence
Blue Shield Promise	*Childhood Immunizations Among Non-Hispanic Members* (Health Equity PIP)	Moderate Confidence
	Well-Child Visits in the First 30 Months of Life	Low Confidence
CalOptima	*Breast Cancer Screening Among Chinese and Korean Members* (Health Equity PIP)	High Confidence
	Well-Child Visits in the First 15 Months of Life	High Confidence
CalViva	*Breast Cancer Screening Among Hmong-Speaking Members* (Health Equity PIP)	High Confidence
	Childhood Immunizations	High Confidence
CCAH	*Child and Adolescent Well-Care Visits Among Members Residing in Merced County* (Health Equity PIP)	High Confidence
	Childhood Immunizations	Moderate Confidence
CCHP	*Diabetes Control Among Members Residing in Specific Regions of Contra Costa County* (Health Equity PIP)	High Confidence
	Well-Child Visits (Ages 3 to 6)	High Confidence

MCMC Plan Name	PIP Topic	Final Confidence Level
CenCal	*Postpartum Care for Members Residing in San Luis Obispo County* (Health Equity PIP)	High Confidence
	Well-Child Visits in the First 15 Months of Life	High Confidence
CHG	*Adolescent Well-Care Visits (Ages 12 to 17)*	High Confidence
	Cervical Cancer Screening Among Black/African-American Members (Health Equity PIP)	Moderate Confidence
CHW	*Breast Cancer Screening Among Members Living with Disabilities in Region 1* (Health Equity PIP)	Low Confidence
	Childhood Immunizations	Low Confidence
GCHP	*Adolescent Well-Care Visits (Ages 12 to 17)*	High Confidence
	Cervical Cancer Screening Among Members Residing in Area 5 (Health Equity PIP)	High Confidence
Health Net	*Breast Cancer Screening Among Russian Members in Sacramento County* (Health Equity PIP)	High Confidence
	Childhood Immunizations	High Confidence
HPSJ	*Adolescent Well-Care Visits (Ages 12 to 21)*	High Confidence
	Cervical Cancer Screening Among White Members Residing in Stanislaus County (Health Equity PIP)	Low Confidence
HPSM	*Adolescent Well-Care Visits (Ages 18 to 21)*	No Confidence
	Breast Cancer Screening Among African-American Members (Health Equity PIP)	No Confidence
IEHP	*Adolescent Well-Care Visits (Ages 18 to 21)*	Moderate Confidence
	Controlling High Blood Pressure Among African-American Members (Health Equity PIP)	High Confidence

MCMC Plan Name	PIP Topic	Final Confidence Level
Kaiser NorCal	*Childhood Immunizations*	High Confidence
	Hypertension Control Among African-American Members Living in South Sacramento (Health Equity PIP)	High Confidence
Kaiser SoCal	*Adolescent Well-Care Visits (Ages 12 to 21)*	High Confidence
	Well-Child Visits Among Members 7 to 11 Years of Age (Health Equity PIP)	High Confidence
KHS	*Asthma Medication Ratio*	High Confidence
	Well-Child Visits Among Members Living in Central Bakersfield (Health Equity PIP)	Moderate Confidence
L.A. Care	*Childhood Immunizations*	High Confidence
	Diabetes Among African-American Members (Health Equity PIP)	Moderate Confidence
Molina	*Childhood Immunizations*	High Confidence
	Diabetes Control Among African-American Members Residing in Sacramento County (Health Equity PIP)	High Confidence
Partnership	*Breast Cancer Screening Among Members Living in Rural and Small Counties* (Health Equity PIP)	High Confidence
	Well-Child Visits in the First 15 Months of Life	High Confidence
SCFHP	*Adolescent Well-Care Visits in Network 20* (Health Equity PIP)	Low Confidence
	Lead Screening in Children	Moderate Confidence
SFHP	*Breast Cancer Screening Among African-American Members* (Health Equity PIP)	Low Confidence
	Well-Child Visits in the First 15 Months of Life	No Confidence

MCMC Plan Name	PIP Topic	Final Confidence Level
Population-Specific Health Plans		
AHF*,^	*Controlling High Blood Pressure*	No Confidence
	Human Immunodeficiency Virus (HIV) Viral Load Suppression	No Confidence
SCAN^	*Breast Cancer Screening*	No Confidence
	Diabetes Control Among Spanish-Speaking Members (Health Equity PIP)	No Confidence

Performance Improvement Project Interventions

Table B.2 through Table B.4 present descriptions of interventions that the MCMC plans tested for the 2020–22 PIPs. The tables also indicate whether the MCMC plans determined, based on intervention testing results, to adopt, adapt, abandon, or continue testing each intervention.

Table B.2—Managed Care Health Plans
2020–22 Health Equity Performance Improvement Project Interventions

*The MCP did not have enough data to demonstrate an identified health disparity; therefore, DHCS waived the requirement for the MCP to conduct a PIP on a health disparity.

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
Breast Cancer Screening			
AAH	*Breast Cancer Screening Among African Americans*	The MCP tested a member incentive intervention at a low-performing provider office. Of 395 members who were sent a text message regarding the member incentive, 78 completed a breast cancer screening. The MCP plans to continue implementing the intervention at the provider's office and expand the intervention to additional low-performing providers.	Adopt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
CalOptima	*Breast Cancer Screening Among Chinese and Korean Members*	The MCP held four mobile mammography community events at a low-performing provider office. The MCP indicated that while it was unable to target Chinese members, 79 Korean-speaking members received a breast cancer screening at these events. For the first event, the MCP sent mailers about the mobile mammography event; however, this type of outreach was not successful. In the subsequent events, in addition to the mailers, the provider office health navigator also telephonically outreached the members. The MCP indicated better success in screening completion among members who received telephonic outreach by the health navigator. The MCP plans to host mobile mammography events that will target both Korean and Chinese members at additional provider sites.	Adopt
CalViva	*Breast Cancer Screening Among Hmong-Speaking Members*	The MCP hosted an educational event. Out of 219 eligible members, only 15 members attended the event, and only a few members scheduled and completed a mammogram.	Abandon
		The MCP hosted four mobile mammography events. Across the four events, 121 eligible members completed a mammogram. As part of the intervention, the MCP provided incentives to members for completing their mammograms. The MCP indicated that the two 25-pound bags of rice option was a more popular incentive compared to the gift card option.	Adopt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
CHW	*Breast Cancer Screening Among Members Living with Disabilities in Region 1*	The MCP tested providing care coordination for breast cancer screening services. The provider partner used a screening tool to triage members to either a mobile mammography location or to an imaging center that could accommodate members with physical disabilities. The intervention did not achieve significant improvement in outcomes; therefore, the MCP indicated that it adapted the intervention to add sending reminder mailers to members to schedule their mammograms with the nearest Americans with Disabilities Act (ADA) compliant imaging centers by December 31, 2022.	Adapt
Health Net	*Breast Cancer Screening Among Russian Members in Sacramento County*	The MCP partnered with clinics to conduct outreach and care coordination to Russian members for breast cancer screening services. One of the partners experienced challenges due to the effects of the Russian/Ukrainian war on Russian members, and only a small percentage of the members this partner reached completed a breast cancer screening. The other clinic partners reached 64 percent of eligible members, with 54 percent scheduling and 46 percent completing a breast cancer screening. The MCP also offered an incentive to members who completed their breast cancer screening and provided a gift card to the clinics' outreach staff.	Adopt
HPSM	*Breast Cancer Screening Among African-American Members*	The MCP conducted targeted outreach at a low-performing provider office to explore barriers and facilitate breast cancer screenings. During the intervention testing period, 11 of 52 members who were outreached completed a breast cancer screening.	Abandon
Partnership	*Breast Cancer Screening Among Members Living*	The MCP conducted three mobile mammography events which resulted in 139 completed mammograms. The MCP plans to spread the intervention throughout its network.	Adopt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
	in Rural and Small Counties	The MCP trained medical assistants to conduct member outreach and order a mammogram for the member. The trainings resulted in the medical assistants ordering 210 mammograms. The MCP plans to spread the intervention throughout its network.	Adapt
SFHP	*Breast Cancer Screening Among African-American Members*	The MCP tested providing members with patient navigation services. During the intervention testing period, only 22 members who enrolled in patient navigation services received a mammogram.	Adapt
Cervical Cancer Screening			
Anthem Blue Cross	*Cervical Cancer Screening Among Vietnamese Members*	The MCP conducted a training for four of its primary care providers (PCPs) about incorporating into their practices cultural sensitivity and health literacy principles related to well-woman care. Two of the four PCP clinics agreed to participate in the intervention and made changes in their processes.	Adopt
		The MCP conducted group member educational sessions. The MCP documented that of the 96 members who were outreached to attend the group education sessions, only a few members attended a session, and no members completed a cervical cancer screening.	Abandon
CHG	*Cervical Cancer Screening Among Black/African-American Members*	The MCP and its provider partners used multiple outreach methods to contact Black/African-American members to schedule cervical cancer screening appointments. The MCP also offered member incentives. The intervention resulted in 184 Black/African-American women completing a cervical cancer screening.	Abandon

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
GCHP	*Cervical Cancer Screening Among Members Residing in Area 5*	The MCP conducted a member outreach campaign that included the MCP sending a co-branded letter to members in the target age group who were assigned to the clinic partner and who were due for a cervical cancer screening. The letter informed the members that they would receive a gift card incentive for completing their screening, and 121 members received the incentive. The MCP adapted the intervention to include Saturday Pap smear clinics, and 86 members completed their screening during these Saturday clinics.	Adapt
HPSJ	*Cervical Cancer Screening Among White Members Residing in Stanislaus County*	The MCP conducted member outreach campaigns to remind eligible members that they were due for their cervical cancer screenings and provided the provider's contact information to schedule an appointment. Of the 176 members who were contacted, 22 members completed their cervical cancer screening.	Abandon
Controlling High Blood Pressure			
IEHP	*Controlling High Blood Pressure Among African-American Members*	The MCP conducted two interventions. The first was a targeted medication review to encourage providers to switch members to a 90-day supply for their antihypertensive medications. For the second intervention, the MCP conducted a targeted medication review for the pharmacists to outreach and encourage members to switch to a 90-day supply or auto-refill for their antihypertensive medications. As a result of both interventions, 198 members filled a 90-day prescription for antihypertensive medications. The MCP determined to adopt both interventions.	Adopt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
Kaiser NorCal	*Hypertension Control Among African-American Members Living in South Sacramento*	The MCP tested a systematic bulk order approach to providing home blood pressure monitors to members with uncontrolled hypertension. The MCP sent blood pressure monitors to 143 members. After months of follow-up, the MCP successfully documented blood pressure measurements in 127 members' medical charts and confirmed that 59 of those members had controlled blood pressure.	Adopt
		The MCP tested encouraging members to record blood pressure measurements using a quick response (QR) code. During the intervention testing, the MCP determined that members prefer personal connections (i.e., texts or phone calls) for sharing blood pressure measurements over using a QR code.	Abandon
		The MCP tested having clinical health educators conduct face-to-face visits with eligible members with hypertension. During the intervention period, 136 members were invited to the face-to-face clinical health education appointment; however, only 24 members attended the appointment, and only a few of those members had controlled blood pressure. The MCP determined that the intervention did not improve members' blood pressure control.	Adapt
Diabetes Control			
Aetna*	*Diabetes Control*	The MCP offered medically tailored meals to members diagnosed with diabetes, and 109 members participated in the program.	Abandon
		The MCP conducted an interactive voice response (IVR) campaign, which used automated calling to contact members and transfer them to Member Services to schedule their HbA1c test appointment. The MCP reached 962 members through this intervention.	Adopt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
CCHP	*Diabetes Control Among Members Residing in Specific Regions of Contra Costa County*	The MCP outreached to eligible members to encourage them to use a cellular-enabled smart blood glucose meter and enroll in one-on-one care management services delivered by a registered nurse, clinical dietitian, or certified diabetes care and education specialist. Of the 312 members who enrolled in the program, 72 achieved diabetes control. Additionally, more than half of the members (55.6 percent) had improved HbA1c levels during their repeat measurement after they enrolled in the program.	Adopt
L.A. Care	*Diabetes Control Among African-American Members*	The MCP conducted a member text messaging campaign that sent at least three health education content messages to members who opted into the campaign. Most of the members who participated in the campaign attended a diabetes provider visit within four months after the text messages were sent, and half of the intervention participants had HbA1c levels less than 9 percent.	Adapt
		The MCP health educators conducted telephonic outreach and sent mailers to members with a missing HbA1c value or HbA1c level of less than 9 percent. The intervention resulted in 44 members receiving educational information on local resources and the importance of medication adherence.	Abandon
Molina	*Diabetes Control Among African-American Members Residing in Sacramento County*	The MCP mailed 127 in-home HbA1c test kits to eligible African-American members in Sacramento County, which resulted in 43 members completing an HbA1c test—19 by completion of the in-home test kit and 24 by completion of a laboratory-based test. The MCP's case management team conducted outreach and education to augment the initial mailing of the kits for members who either did not receive their kits or who lost or discarded the kits. As a result, 51 members completed a laboratory-	Adopt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
		based HbA1c test; however, no members completed an in-home test. The MCP mailed an additional 209 in-home HbA1c test kits; of those, 25 members returned a completed in-home test kit, and 104 members completed a laboratory-based HbA1c test. The MCP determined more timely case management outreach and education about the importance of obtaining an HbA1C test was a valuable component of the home HbA1c test intervention.	
Child and Adolescent Health			
Blue Shield Promise	*Childhood Immunizations Among Non-Hispanic Members*	The MCP funded health navigators to outreach to non-Hispanic members to address immunization concerns, conduct member education, and help the members with scheduling immunization appointments. During the intervention testing period, the MCP indicated that out of 86 members who had not completed the full *Childhood Immunization Status—Combination 10* measure schedule, 27 members had the health navigator schedule an appointment for them to complete their immunization schedule.	Adopt
CCAH	*Child and Adolescent Well-Care Visits Among Members Residing in Merced County*	The MCP worked with its provider partner to increase the capacity for in-person child and adolescent well-care visit appointments by increasing the clinic schedule from two to four days a week. The provider partner exceeded the number of well-care appointments scheduled prior to increasing the clinic days by 420 percent.	Adopt
		The MCP implemented a recall system for members who had not completed their annual well-care visit by having its provider partner outreach to eligible members to schedule a well-care visit with and without an incentive gift card in two testing cycles. As a result of this intervention, 189 members completed a well-care visit. The MCP indicated that more testing is	Adopt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
		needed to better understand the impact of the member incentive.	
Kaiser SoCal	*Well-Child Visits Among Members 7 to 11 Years of Age*	The MCP sent a standardized, automated birthday postcard with a reminder for well-child visits to members 7 to 11 years of age. During the intervention testing period, out of 2,351 members who were sent the birthday card, 430 scheduled the appointment. Additionally, the MCP's data during the intervention testing period showed that 365 well-child visit appointments were scheduled within 60 days of the birthday postcard reminder outreach; out of those, 287 visits were completed. The MCP determined the intervention was very successful in improving the well-child visit rate.	Adopt
KHS	*Well-Child Visits Among Members Living in Central Bakersfield*	The MCP conducted multi-modal member outreach via robocalls and mailers. After receiving the outreach, 77 members completed a well-child visit in the first testing cycle, and 154 members completed a visit in the second testing cycle. The MCP conducted limited outreach during the third testing cycle and thus did not achieve success in getting members to complete their well-child visits. The MCP added a text messaging campaign in the fourth testing cycle, wherein 51 members completed a well-child visit after receiving the intervention. The MCP determined that members who were outreached through two or more modalities had a higher percentage rate of closing their gap in care. The MCP decided to expand the intervention to additional performance measures.	Adopt
SCFHP	*Adolescent Well-Care Visits in Network 20*	The MCP intended to test a member health education and incentive intervention; however, the MCP could not carry out the intervention as planned due to delays in executing a contract with a health engagement vendor.	Abandon

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
Women's Health			
CenCal	*Postpartum Care for Members Residing in San Luis Obispo County*	The MCP developed and tested a process for identifying new mothers within 10 days of their deliveries and subsequently contacting them to help with scheduling and attending their postpartum visits. In the first testing cycle, the MCP successfully contacted and scheduled postpartum visits for 37 members, and of those, 36 members attended the postpartum visit. In the second testing cycle, the MCP successfully contacted and scheduled postpartum visits for 56 members, and all 56 members attended their postpartum visit.	Adapt

Table B.3—Managed Care Health Plans
2020–22 Child and Adolescent Health Performance Improvement Project Interventions

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
Childhood Immunizations			
Anthem Blue Cross	*Childhood Immunizations*	The MCP hosted two flu shot clinic day events. Out of 22 members contacted for the first event and 56 members contacted for the second event, only a few members scheduled and attended their appointments.	Abandon
		The MCP held three virtual health education sessions to improve members' understanding of the importance of immunizations. The MCP documented that out of 42 members who were contacted to attend the virtual health education sessions, only a few members attended the sessions, and none scheduled or attended an immunization appointment.	Abandon

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
CalViva	*Childhood Immunizations*	The MCP's provider partner conducted a texting campaign to parents/guardians, sending educational messages in English and Spanish about the importance of completing childhood immunizations. During the intervention testing period, of the 2,159 text messages sent, 140 members scheduled an immunization appointment, and 105 members completed their appointment. The MCP decided to expand the campaign to other clinics within the targeted federally qualified health center (FQHC) and within Fresno County.	Adapt
		The MCP hosted immunization events on three Saturdays and offered members incentives such as diaper backpacks filled with baby wipes, rattles, first aid kits, and sunscreen. As a result of all three events, 64 members received their needed immunizations. The MCP decided to expand the intervention to other clinics within the targeted FQHC and within Fresno County.	Adapt
CCAH	*Childhood Immunizations*	The MCP tested a member incentive intervention in collaboration with its provider partner, which scheduled members due for their first or second flu vaccination. During the intervention testing period, the MCP documented that 51 members completed their flu vaccinations and received the gift card incentive. While the MCP indicated that it will not replicate this incentive, it will offer a monetary incentive of $100 for members who receive all needed vaccinations by their second birthday.	Continue Testing
		The MCP tested an intervention to resolve data issues with the provider partner who was not sending data to the local immunization registry.	Adopt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
CHW	*Childhood Immunizations*	The MCP outreached to pregnant members to provide education about infant vaccines. The MCP documented that 26 pregnant members received education regarding infant vaccines across two testing cycles; however, the MCP did not provide data on whether those members initiated infant vaccinations. The MCP will continue the member outreach intervention.	Adopt
Health Net	*Childhood Immunizations*	The MCP worked with a low-performing provider partner to make workflow changes to maximize opportunities for childhood vaccine completion. In the first testing cycle, out of 295 eligible members, only 20 members were successfully outreached by the provider partner, and 15 members were scheduled for a vaccine appointment. Due to the low outreach rate and provider resources shortage, the MCP conducted the outreach in the second testing cycle, wherein out of 344 eligible members, 119 members were successfully outreached, and 78 members were scheduled for a vaccine appointment.	Adopt
Kaiser NorCal	*Childhood Immunizations*	The MCP outreached to parents/guardians of members who missed their scheduled well-child visits to help with rescheduling the visits and encourage completion of recommended vaccinations. Of the 173 members on the missed appointment list, 99 attended their rescheduled visit. Of the 99 who attended, 72 were self-scheduled and 27 were booked following the outreach.	Abandon
		The MCP conducted pre-appointment outreach calls to parents/guardians of members who had well-child visit appointments scheduled at a provider partner office in efforts to prevent no-shows. The MCP's aim was to improve the well-child visit	Adapt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
		rates so that the provider partner could encourage parents/guardians to obtain the recommended vaccinations during the visits. During the first testing cycle, the MCP outreached to parents/guardians of members ages 4 months to 7 months and expanded calls in the second testing cycle to include members 2 months to 24 months, and in the third testing cycle to include members 17 months to 20 months. The MCP determined that the pre-appointment outreach helped to decrease the number of missed appointments and learned that outreaching to members' parents/guardians closer to the date of the visit was most impactful. The MCP decided to make the pre-appointment outreach a standard practice throughout the Sacramento Valley service area.	
L.A. Care	*Childhood Immunizations*	The MCP's provider partner used a missing vaccine report to conduct member outreach calls to schedule members for their immunization appointments. During the three testing cycles, 94 members were scheduled and attended their immunization appointments. The MCP plans to create a similar report for well-child visits and to adopt a more holistic approach by addressing both the vaccine and well-care visit issues at once.	Adapt
Molina	*Childhood Immunizations*	The MCP worked with a provider partner to reconcile undisclosed records within the California Immunization Registry 2. During the intervention testing period, the MCP documented that the status was changed from undisclosed to disclosed in the registry for 21 of 25 members under the age of 2 years. The MCP decided to create best practice workflows for providers in all counties to ensure members' statuses are not left as	Adopt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
		undisclosed in the registry. The MCP indicated that changing the status of records in the California Immunization Registry 2 will result in more accurate immunization data and favorable outcomes with other interventions.	
		The MCP implemented IVR reminder calls to parents/guardians of members who were assigned to a provider partner to encourage timely immunizations. During the intervention testing period, 24 of 90 members who received an IVR reminder call completed their immunizations. The MCP decided to expand the intervention to all members in need of completing the *Childhood Immunization Status—Combination 10* measure vaccines.	Adopt
Well-Care Visits			
AAH	*Child and Adolescent Well-Care Visits (Ages 3 to 21)*	The MCP sent birthday mailers to parents/ guardians of eligible members that included an offer to receive a $25 gift card at the completion of the members' well-care visits. During the intervention testing period, 70 of the 971 members who were sent birthday mailers completed a well-care visit. The MCP will continue testing the intervention.	Continue Testing
Aetna	*Well-Child Visits (Ages 3 to 11)*	The MCP created a flag in the MCP's Member Services system to easily identify members assigned to a provider partner who were due for a well-child visit. The Member Services staff conducted a three-way call with the member and the provider partner office to schedule the well-child visit.	Adapt
Blue Shield Promise	*Well-Child Visits in the First 30 Months of Life*	The MCP health navigators outreached to parents/guardians of eligible members to help with scheduling their well-child visits. Sixteen members completed their well-child visits by the end of the intervention testing period. The	Adopt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
		MCP indicated that the results did not achieve the projected outcome; however, the MCP adopted the intervention.	
		The MCP invited members to enter a raffle upon completion of their well-child visits. During the intervention testing period, 42 members were contacted and scheduled their appointments; however, only a few members completed their well-child visits. The MCP decided to adopt the intervention due to positive feedback received from members' parents/guardians.	Adopt
		The MCP offered an incentive to parents/guardians of eligible members upon completion of members' well-child visits. During the intervention testing period, of 159 eligible members, 20 members completed their well-child visits and received the incentive. The MCP indicated that it would continue the intervention in 2023.	Continue Testing
CalOptima	*Well-Child Visits in the First 15 Months of Life*	The MCP established data sharing procedures with a provider partner office to identify members due for their well-child visits in order to conduct outreach to the eligible members' parents/guardians. The MCP was successful in reconciling the data for all eligible members, and the intervention enabled the provider office to identify all of its members who were due for a well-child visit that would contribute to the *Well-Child Visits in the First 15 Months of Life* measure rate. The MCP and the provider partner identified data gaps between what is captured in the MCP's member detail report and actual well-child visits rendered by the provider partner. The MCP decided to adopt the intervention and continue sending the member detail	Adopt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
		report to the provider office and to expand the intervention to additional provider offices.	
CCHP	*Well-Child Visits (Ages 3 to 6)*	The MCP conducted outreach to parents/guardians of African-American members 3 to 6 years of age to schedule well-child visits. Of the 57 parents/guardians who were outreached at the provider partner, 27 scheduled a well-child visit, and 23 members attended the appointment. In the second testing cycle, the MCP outreached to parents/guardians of all eligible members. Of the 277 parents/guardians who were outreached, 134 scheduled a well-child visit, and 55 members attended the appointment. The MCP expanded its member outreach team to six full-time staff members to conduct future outreach calls.	Adopt
CenCal	*Well-Child Visits in the First 15 Months of Life*	The MCP developed a process to identify members who were due for a well-child visit, and the population health nurse attempted to call each member at least three times to schedule a well-child visit appointment. In the first testing cycle, 27 of the 36 members contacted scheduled and attended their appointments. In the second testing cycle, 78 of the 91 members contacted scheduled and attended their appointments. To promote systemwide changes within the MCP's provider network, the MCP stopped having the population health nurse conduct the outreach calls and instead created an automated gaps-in-care report for providers to use to outreach to parents/guardians about the importance of timely well-child visits.	Adapt
CHG	*Adolescent Well-Care Visits (Ages 12 to 17)*	The MCP used multiple outreach methods to educate parents/guardians about well-care visits and help with scheduling members' appointments. Through the four cycles, the	Adapt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
		MCP tested outreach calls, text messaging, and member incentives. As a result of all four testing cycles, 648 members completed their well-care visits. The MCP added staff members to continue making the outreach calls and offering the member incentives.	
GCHP	*Adolescent Well-Care Visits (Ages 12 to 17)*	The MCP outreached to parents/guardians of eligible members and offered a $15 gift card for completing their well-care visits. As a result of the outreach incentive intervention, 83 members completed their well-care visits.	Adapt
		The MCP tested conducting an audit to determine if members were incorrectly included in the monthly gaps-in-care reports. The audit resulted in the MCP resolving all cases of well-care visits being coded incorrectly, reducing the percentage of members incorrectly coded from 54 percent to 0 percent.	Adopt
HPSJ	*Adolescent Well-Care Visits (Ages 18 to 21)*	The MCP collaborated with its provider partners to outreach to members to help schedule adolescent well-care visits. During the four testing cycles, 1,339 members were scheduled for a well-care visit. Of the 419 members who had an appointment scheduled in the fourth cycle, 294 completed their well-care visits. The MCP added five health navigators and decided to expand the intervention to additional FQHCs and other providers.	Adapt
HPSM	*Adolescent Well-Care Visits (Ages 18 to 21)*	The MCP offered a $25 gift card to members ages 18 to 21 years who were assigned to the provider partner for completing their adolescent well-care visits. The MCP experienced delays in implementing the intervention which resulted in the MCP sending mailers to eligible members rather	Continue Testing

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
		than making outreach calls. The MCP plans to continue testing the intervention.	
IEHP	*Adolescent Well-Care Visits (Ages 18 to 21)*	The MCP conducted two interventions. For the first intervention, the provider partner's medical assistants conducted member outreach calls to eligible members to schedule their adolescent well-care visits. For the second intervention, the provider partner texted eligible members about the importance of adolescent well-care visits and offered to help with scheduling appointments. As a result of both interventions, 40 members completed their well-care visits. The MCP abandoned both interventions due to the low number of members impacted.	Abandon
Kaiser SoCal	*Adolescent Well-Care Visits (Ages 12 to 21)*	The MCP sent standardized, automated birthday postcards with a reminder to complete well-care visits to members ages 12 to 17 years in three testing cycles. During the intervention testing period, 193 of the 1,123 members who were sent birthday postcards scheduled well-care visits. Additionally, 154 members scheduled their well-care visits within 60 days of the birthday postcard reminder outreach, and 106 of those members completed the visits.	Adopt
Partnership	*Well-Child Visits in the First 15 Months of Life*	The MCP offered Saturday well-child visit appointments for members 0 to 15 months of age who were assigned to a provider partner. During the two testing cycles, 506 members were scheduled for a well-child visit, and 375 of those members completed their well-child visits. The MCP plans to share and encourage adoption of Saturday appointment availability across its primary care network in the counties in which the MCP operates.	Adopt

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
SFHP	*Well-Child Visits in the First 15 Months of Life*	The MCP conducted targeted outreach and offered financial incentives to parents/guardians of eligible members who completed their well-child visits.	Continue Testing
Other Child and Adolescent Health Topics			
KHS	*Asthma Medication Ratio*	The MCP outreached to eligible members and tracked the number of members who agreed to participate in the disease management program after the members were successfully contacted. The MCP did not track members who agreed to participate in the program during the first testing cycle; however, the MCP reported that 56 percent of members were successfully contacted in testing cycle 1. In testing cycles 2, 3, and 4, 43 percent, 52 percent, and 33 percent, respectively, of members successfully contacted agreed to participate in the program.	Abandon
		The MCP requested medical records from PCPs to review and use while filling out the Asthma Action Plan and educating members about medications for their asthma conditions. In the first two testing cycles, the MCP received 100 percent of the records requested; however, in cycles 3 and 4, the MCP received 75 percent and 33 percent of the records, respectively. The MCP indicated staffing shortages at PCP offices as the reason for lower success rates in testing cycle 4.	Abandon
		The MCP's disease management staff explained the Asthma Action Plan during members' initial assessment visits and mailed the Asthma Action Plan to members after the assessment. The disease management staff helped members review and update the Asthma Action Plan as needed and encouraged members to take the Asthma	Abandon

MCP Name	PIP Topic	Intervention Description	Adopt, Adapt, Abandon, or Continue Testing
		Action Plan to their PCPs to review during visits. In three of the four testing cycles, 100 percent of the members who agreed to participate in the disease management program completed their Asthma Action Plan. In one of the four testing cycles, 66 percent completed the Asthma Action Plan. The MCP determined success with the intervention and indicated the Asthma Action Plan can be easily completed once medical records are available and members are engaged in their health care.	
SCFHP	*Lead Screening in Children*	The MCP educated its provider partners about the gaps-in-care report, importance of blood lead screening, and placing members' blood lead screening orders. During the intervention testing period, 1,922 members completed their blood lead screenings. For future testing cycles, the MCP will test the effectiveness of providing an incentive to members who complete the required screening.	Adopt

Table B.4—Population-Specific Plans
2020–22 Performance Improvement Project Interventions

*The PSP did not have enough data to demonstrate an identified health disparity; therefore, DHCS waived the requirement for the PSP to conduct a PIP on a health disparity.

^The PSP does not serve the child or adolescent population; therefore, DHCS waived the requirement for the PSP to conduct a PIP on child and adolescent health.

PSP Name	PIP Topic	Interventions	Adopt, Adapt, Abandon, or Continue Testing
AHF*,^	*Controlling High Blood Pressure*	The PSP offered to coordinate transportation services for members when scheduling an appointment. The intervention testing resulted in 76 members using the transportation services. The PSP abandoned the intervention because it concluded that the transportation help did not impact blood pressure rates.	Abandon
	Human Immunodeficiency Virus (HIV) Viral Load Suppression	The PSP offered to coordinate transportation services for members when scheduling an appointment. The intervention testing resulted in 595 members using the transportation services. The PSP abandoned the intervention because it concluded that the transportation help did not impact viral load rates.	Abandon
SCAN^	*Breast Cancer Screening*	The PSP provided gaps-in-care reports to provider partners. During the two testing cycles, 960 providers downloaded the gaps-in-care reports. Note that the PSP reported intervention data beyond the SMART Aim end date of December 31, 2022, reporting data through April 1, 2023.	Adopt
	Diabetes Control Among Spanish-Speaking Members (Health Equity PIP)	The PSP referred eligible members to case management/disease management diabetes programs for self-management education and tracked members' engagement in the referred programs. During the two testing cycles, 490 members were referred to diabetes management programs, and 48 members engaged in the programs. For the first cycle, the PSP referred members to its internal programs; and for the second cycle, the PSP also offered programs operated by its delegated providers. The PSP adopted the process of identifying members with uncontrolled diabetes and referring them to both internal and external programs.	Adopt

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

This appendix includes each MCMC plan's self-reported follow-up on the 2021–22 EQR recommendations and HSAG's assessment of the self-reported actions. Additionally, based on its assessment of the 2022–23 EQR activities, HSAG summarizes each MCMC plan's strengths and weaknesses (referred to as "opportunities for improvement" in this appendix) with respect to the quality of, timeliness of, and access to care the MCMC plan furnishes to its members. Based on the assessment, HSAG makes recommendations to each MCMC plan.

Description of Manner in Which MCMC Plan Data Were Aggregated and Analyzed and Conclusions Drawn Related to Quality, Access, and Timeliness

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

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

Aetna Better Health of California

Follow-Up on Prior Year Recommendations

Table C.1 provides EQR recommendations HSAG made to Aetna in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.1 to preserve the accuracy of Aetna's self-reported actions.

Table C.1—Aetna's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Address the findings from the 2021 DHCS Audits & Investigations Division (A&I) Medical Audit of Aetna by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in all categories except Utilization Management.	Aetna has remediated all findings from the 2021 A&I Medical Audit. Aetna implemented the actions recommended by A&I, including actions to address one of the repeat findings for which the plan did not appropriately classify and process call inquiries as member grievances. The MCMC plan implemented a corrective action plan (CAP) to monitor calls and ensure all appeals and grievances are forwarded to the Grievances & Appeals (G&A) Department to be processed. Aetna performs an additional level of quality review of incoming calls. During this quality review, the MCMC plan was able to identify several calls that should have been sent to the G&A Department to be processed. The compliance rate for each missed classification is being tracked monthly. We saw an improvement month after month that calls are being classified and processed correctly. Aetna will continue to conduct quality review to ensure all calls are classified appropriately. In addition, the MCMC plan also trained staff individually on the G&A process.

2021–22 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	The second repeat finding was that Aetna did not have a robust method of identification of eligible California Children Services (CCS) members or a consistent process in place to support referrals to the local CCS programs. To remediate this finding, Aetna updated the current CCS identified member list with specific CCS-related diagnoses. Through stratification, predictive pathway modeling, and enrollment files, the MCMC plan was able to identify eligible CCS members. To support referrals to the local CCS program, Aetna's care managers were able to refer members with CCS-eligible conditions to the local CCS program using the enhanced CCS identified member list. The care manager created a community resource referral event on the care management platform for CCS referral. To ensure a member is accepted into CCS, care managers set reminder tasks in the care management platform every 14 days until confirmation is received. Once a member is accepted, the care manager will close the active care management episode. If a member is not accepted into the CCS program, the care manager will continue with the current care management episode. This process has been successful in ensuring eligible CCS members are being referred to the local CCS programs as necessary.
2. Address the findings from the 2022 A&I Medical and State Supported Services Audits of Aetna by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Case Management and Coordination of Care, Access and Availability of Care, and Member's Rights categories.	Aetna has remediated 16 of the 19 findings from the 2022 A&I Medical Audit. Aetna implemented the actions recommended by A&I. The following repeat findings have been fully remediated: ♦ Case Management/Coordination of Care—*The plan did not have a robust method of identification of eligible members under 3 years of age with specific developmental disabilities that could benefit from Early*

2021–22 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	Start services or a consistent process in place to support referrals to the local regional centers.—Aetna has taken the following actions/made the following changes: ■ Enhanced reporting capabilities to identify members up to 3 years of age who may be eligible to receive services from the Early Start program. The report is sent monthly to the care management team to perform outreach. The team makes a minimum of two attempts to reach a member representative. ■ Care managers will provide program information and help with referring members to the local regional center for further evaluation. ■ Care managers will offer case management services to member-authorized member representatives, including legal guardians. ■ Care managers will create a community resource referral in the case management platform and create a task for two-week follow-up. ■ Care managers will maintain oversight, which consists of monitoring events by type in the care management platform to determine if a referral has documented follow-up. ♦ Behavioral Health Treatment (BHT) Plans—*The plan did not ensure BHT plans are reviewed no less than once every six months and contained transition, crisis, and exit plans.*—To strengthen the BHT plan process, the MCMC plan's behavioral health liaison will now call the provider at five and a half months to request an updated treatment plan and remind the

2021–22 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	provider of the need for inclusion of transition, crisis, and exit plans for approval. The desktop procedure for the BHT plan was updated to include this step in the process, and the utilization management team was educated regarding this change. ♦ Unenrolled Transportation Providers—*The plan did not ensure contracted non-emergency medical transportation (NEMT) providers were enrolled in the Medi-Cal program.*—The plan has taken immediate actions to ensure contracted NEMT providers are enrolled in the Medi-Cal program in order to pay NEMT service claims. Aetna has shared this requirement with our transportation broker, A2C. As a result, A2C has performed the following: ■ Notified providers who had not yet been registered by Medi-Cal that they could no longer provide services for Aetna's members. ■ Updated its network trip assignment protocols to prevent nonregistered providers from being assigned to Aetna's members. ■ Provided a monthly report to Aetna that includes the Medi-Cal registration status of all providers servicing the MCMC plan's members. ■ Provided a monthly report to Aetna of nonregistered providers with a pending status to monitor additional provider capacity that may be available in the future upon registration being completed. ■ Provided a monthly report of claim activity to validate that only Medi-Cal registered providers are being used.

2021–22 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	To ensure ongoing compliance, Aetna conducted an audit of 2022 trips to validate utilization of providers who are Medi-Cal registered. ♦ Privacy Breach—*The plan did not notify the DHCS program contract manager, DHCS privacy officer, and DHCS information security officer within 24 hours by email or fax of the discovery of a breach of protected health information (PHI), did not provide an updated DHCS Privacy Incident Report to the DHCS program contract manager, DHCS privacy officer, and DHCS information security officer within 72 hours of discovery, and did not provide a completed Privacy Incident Report to all required DHCS entities within 10 working days of discovery.* ■ Aetna took immediate actions to ensure notification of a privacy breach is communicated to the Compliance Department first via email to the compliance inbox and that the compliance officer and senior compliance analyst are copied. This will ensure the notification will be received and prompt investigation and reporting will be reported to DHCS in a timely manner. In addition, the MCMC plan developed a new privacy training to reeducate staff members about how to report privacy incidents to the Compliance Department and updated the desktop procedure. Since this remediation effort, the MCMC plan has been successfully reporting in a timely manner to DHCS when there is a privacy incident.

2021–22 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
3. Implement additional quality control processes to ensure supplemental data are appropriately compiled and available for performance measure reporting.	Aetna implemented an annual outreach process by which we outreach to our partners, including but not limited to our independent physician association (IPA) partners and FQHCs, and request any new supplemental data sources, if available. If a new data source is identified, our process consists of the following: ♦ Prior to loading any new data file, the data source undergoes scrutiny by the Data Governance Committee. ♦ The file layout is examined and a sample file is tested prior to the initial production run. ♦ Subsequent data loads are included in routine quality assurance checks as the data move through each integration database and the Quality Performance Reporting Team completes a final flowchart quality assurance check prior to releasing the rates to the MCMC plan.
4. For measures for which Aetna performed below the minimum performance levels in measurement year 2021, assess the factors, which may include coronavirus disease 2019 (COVID-19), that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Aetna should determine whether interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.	Aetna performed below the minimum performance level for 10 measures. There were several factors that affected our performance, including but not limited to COVID-19, member communication, and the need for additional supplemental data sources, provider communication, and health education. Based on the above factors, Aetna implemented the following improvement strategies: ♦ Revamped the Health Education Program. ■ Some examples include development of heart health and maternal health booklets, which are available digitally, and health education courses for child

2021–22 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	and adolescent health, heart health, diabetes, and women's health. ♦ Provider Education Program ■ Some examples include a live provider education training in April 2023 for large-volume provider groups with IPA partnerships. The training targeted the top 20 provider groups per county in San Diego and Sacramento counties that had the largest gaps-in-care volume. ♦ Member Focused Outreach ■ Some examples include National Aetna Quality Management member outreach completed for members needing services related to the following measures: ○ *Childhood Immunization Status—Combination 10* ○ *Developmental Screening in the First Three Years of Life—Total* ○ *Lead Screening in Children* ○ All three *Topical Fluoride for Children* measures ○ Both *Well-Child Visits in the First 30 Months of Life* measures ♦ Bimonthly Calls ■ We implemented bi-monthly calls with our partners to review their current rates for our Tier 1 measures composed of all DHCS-required Managed Care Accountability Set (MCAS) measures that are held to minimum performance levels, plus three weighted NCQA measures. We identify barriers and discuss trends and possible opportunities to improve on identified measures.

2021–22 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	♦ Health and Wellness Campaigns ■ The modality for the outreach campaigns with our vendor is through text messaging, IVR calls, emails, and mailers. We are currently doing campaigns for the following measures: ○ *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* ○ Both *Antidepressant Medication Management* measures ○ *Child and Adolescent Well-Care Visits—Total* ○ *Colorectal Cancer Screening* ○ *Controlling High Blood Pressure—Total* ○ Diabetes measures ○ *Immunizations for Adolescents—Combination 2* ○ Both *Prenatal and Postpartum Care* measures ○ Both *Well-Child Visits in the First 30 Months of Life* measures Aetna has developed a diabetes booklet and heart health booklet. We receive reports from our vendor, and we track the information quarterly. ♦ Community Involvement/County Collaboratives ■ Aetna was a key partner in San Diego County's annual event focused on blood pressure screening and heart health.

Assessment of Aetna's Self-Reported Actions

HSAG reviewed Aetna's self-reported actions in Table C.1 and determined that Aetna adequately addressed the 2021–22 EQR recommendations. Aetna described in detail the steps the MCMC plan took to resolve the findings from the 2021 A&I Medical Audit and 2022 Medical and State Supported Services Audits. Additionally, Aetna summarized process improvements the MCMC plan made to ensure supplemental data are appropriately compiled and available for performance measure reporting. Finally, Aetna reported implementing member- and provider-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2021, including:

- Revised health education materials.
- Implemented provider education programs.
- Conducted member outreach targeting members needing children's preventive services.
- Conducted bimonthly calls with provider partners to review performance measure rates, discuss barriers, and identify opportunities for improvement.
- Conducted member outreach using text messages to improve performance on children's preventive health measures, chronic disease measures, and women's health measures.

The strategies Aetna implemented may have contributed to the rate for the *Childhood Immunization Status—Combination 10* measure improving from below the minimum performance level in measurement year 2021 to above the minimum performance level in measurement year 2022 for San Diego County.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Aetna

Based on the overall assessment of Aetna's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of Aetna's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for Aetna show that the MCMC plan was fully compliant with most Code of Federal Regulations (CFR) standards.

- The HSAG auditor determined that Aetna followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- For Sacramento County, Aetna performed above the high performance level in measurement year 2022 for the *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* measure.
- HSAG assigned a *High Confidence* level to Aetna's 2020–22 *Diabetes Control* PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. Aetna's member outreach PIP intervention contributed to an increase in the number of members accessing HbA1c testing appointments.
- While HSAG assigned a *No Confidence* level to Aetna's 2020–22 *Well-Child Visits (Ages 3 to 11)* PIP, reflecting that the MCMC plan did not follow the approved PIP methodology, based on intervention testing results, the MCMC plan determined to adapt the tested intervention of conducting three-way calls with the MCMC plan Member Services staff, select providers, and members to schedule well-child visits, to include all members due for well-care visits.

Opportunities for Improvement

- DHCS identified findings within three of the CFR standards during the DHCS compliance review scoring process for Aetna.
- Across both reporting units in measurement year 2022, Aetna performed below the minimum performance levels for 23 of the 30 measure rates that HSAG compared to benchmarks (77 percent).

2022–23 External Quality Review Recommendations

Aetna's contract with DHCS ended December 31, 2023; therefore, HSAG makes no recommendations to the MCMC plan since Aetna will not be under contract with DHCS in July 2024 when HSAG requests summaries of how MCMC plans addressed the 2022–23 EQR recommendations. Note that while Aetna's contract ends December 31, 2023, DHCS will require the MCMC plan to participate in the measurement year 2023 performance measure validation audit process. HSAG will report Aetna's measurement year 2023 performance measure results in the 2023–24 MCMC EQR technical report.

AIDS Healthcare Foundation

Follow-Up on Prior Year Recommendation

Table C.2 provides the EQR recommendation HSAG made to AHF in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendation. Please note that HSAG made minimal edits to Table C.2 to preserve the accuracy of AHF's self-reported actions.

Table C.2—AHF's Self-Reported Follow-Up on the External Quality Review Recommendation from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendation Directed to AHF	Self-Reported Actions Taken by AHF during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
1. Continue to work with DHCS to fully resolve all findings from the 2021 A&I Medical Audit of AHF.	AHF has worked with DHCS to fully resolve the findings from the 2021 A&I Medical Audit. All findings and actions recommended by A&I have been reviewed. A CAP completed by AHF involved a detailed analysis, interventions, implementation, and monitoring. Monitoring continues as AHF waits for any additional concerns from DHCS or a response that final resolution is completed.

Assessment of AHF's Self-Reported Actions

HSAG reviewed AHF's self-reported actions in Table C.2 and determined that AHF adequately addressed the 2021–22 EQR recommendation. AHF indicated that the MCMC plan submitted documentation to DHCS and has worked with DHCS to fully resolve all findings from the 2021 A&I Medical Audit. AHF stated that it is awaiting confirmation from DHCS that the MCMC plan has adequately resolved all findings.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for AHF

Based on the overall assessment of AHF's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of AHF's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for AHF show that the MCMC plan was fully compliant with all CFR standards.
- The HSAG auditor determined that AHF followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- AHF performed above the high performance levels in measurement year 2022 for the following two measure rates that HSAG compared to benchmarks:
  - *Controlling High Blood Pressure—Total*
  - *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
- While HSAG assigned a *No Confidence* level to both of AHF's 2020–22 PIPs, reflecting that the MCMC plan did not follow the approved PIP methodologies, AHF noted lessons learned from conducting both PIPs and indicated that the MCMC plan will apply these lessons learned moving forward.

Opportunities for Improvement

Based on the overall assessment of AHF's delivery of quality, accessible, and timely care through the activities described in this volume, HSAG identified no specific opportunities for improvement.

2022–23 External Quality Review Recommendations

HSAG has no recommendations for AHF. In the next annual review, HSAG will evaluate the continued successes of AHF.

Alameda Alliance for Health

Follow-Up on Prior Year Recommendations

Table C.3 provides EQR recommendations HSAG made to AAH in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.3 to preserve the accuracy of AAH's self-reported actions.

Table C.3—AAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Continue to work with DHCS to fully resolve all findings from the 2019 and 2021 A&I Medical and State Supported Services Audits of AAH.	On July 12, 2023, AAH received the official CAP closure notification for the 2019 DHCS audits. From November 2021 through October 2022, AAH provided supporting documents to DHCS related to our 2021 CAP. All action items for the repeat findings have been implemented. AAH has not yet received the official CAP closure notification for the 2021 DHCS audits.
2. Address the findings from the 2022 A&I Medical Audit of AAH by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in all five categories with findings.	AAH has worked consistently to address all findings from the 2022 A&I Medical Audit. AAH has updated policy documents and workflows, provided training for staff members and providers, and worked with our delegate partners to address all findings related to delegation. In June 2023, AAH provided supporting documents related to our CAP implementation to DHCS. All action items for the repeat findings have been implemented.

2021–22 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
3. Assess whether the member outreach and incentive strategies the plan previously implemented to improve breast cancer screening rates need to be revised or abandoned based on AAH's performance for the *Breast Cancer Screening—Total* measure remaining below the minimum performance level in measurement year 2021.	Breast Cancer Screening Disparity PIP ♦ The member outreach and incentive strategy implemented in 2022 was successful. Seventy-eight African-American women, ages 52 to 74, completed a breast cancer screening between February 2022 and December 2022. Furthermore, our partnering provider, LifeLong Medical Care, increased breast cancer screening rates from measurement year 2021 to measurement year 2022 for African-American women ages 52 to 74. This incentive program was extended to all women ages 52 to 74 assigned to LifeLong Medical Care, resulting in 133 women completing a breast cancer screening overall. This contributed to AAH's *Breast Cancer Screening—Total* measure rate improving from measurement year 2021 to measurement year 2022, and the rate exceeding the minimum performance level.
4. For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in AAH performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors.	To address these two measures, AAH focused on getting children to see their PCPs for a well-care visit, educating providers on Healthcare Effectiveness Data and Information Set (HEDIS) specifications, and sharing best practices. This was done by employing the projects indicated below: ♦ HEDIS Crunch Well-Care Visit—Ages 0 to 21 years—July 2022 through December 2022. This project was adapted from 2021 with two changes: (1) the age range was extended to include children 0 to 2 years of age, and (2) the timeline was changed from November to July to align with back-to-school preparations. In 2022, AAH partnered with 18 pediatric/PCP sites to conduct outreach and offer a $25 incentive to complete well-care visit exams. As a

2021–22 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	result, more than 1,242 members completed a well-care visit. This project contributed to AAH's *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure rate improving to above the minimum performance level in measurement year 2022. ♦ First 5 Alameda County—July 2022 through June 2023. In partnership with First 5, AAH conducted outreach to members ages 0 to 5 years. First 5 results show successful outreach to 3,773 members, and more than 896 members completed a well-care visit. ♦ Provider Education—Hosted two provider webinars focused on the *Well-Child Visits in the First 30 Months of Life* measures. AAH trained providers on HEDIS measure specifications and AAH's pay-for-performance (P4P) program, and AAH shared best practices from high-performing providers. Measure highlights tools were created to further support provider knowledge of the measures. More than 18 providers attended the webinars. ♦ Texting Campaign in partnership with our pediatric delegate, Children First Medical Group. AAH successfully launched a texting campaign aimed at sending reminder text messages to parents/guardians of children ages 0 to 2 years, encouraging them to complete a well-care visit. A total of 39,194 members received a text message, with 15.50 percent of these members reporting a completed or scheduled appointment.

Assessment of AAH's Self-Reported Actions

HSAG reviewed AAH's self-reported actions in Table C.3 and determined that AAH adequately addressed the 2021–22 EQR recommendations. AAH indicated that the MCMC plan submitted documentation to DHCS regarding findings from the 2019, 2021, and 2022 A&I Medical Audits. AAH noted that DHCS closed the CAP for the 2019 Medical and State Supported Services Audits and stated that the MCMC plan is waiting for notification from DHCS that the CAPs from the 2021 and 2022 audits are closed.

AAH reported that the member outreach and incentive strategy the MCMC plan implemented as part of its *Breast Cancer Screening Among African Americans* Health Equity PIP contributed to the improvement from measurement year 2021 to measurement year 2022 for the *Breast Cancer Screening—Total* measure rate and the rate for this measure moving from below the minimum performance level in measurement year 2021 to above the minimum performance level in measurement year 2022. To address AAH performing below the minimum performance levels for the two *Well-Child Visits in the First 30 Months of Life* measures in measurement year 2021, the MCMC plan reported implementing member- and provider-focused interventions. These interventions may have contributed to the rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure moving from below the minimum performance level in measurement year 2021 to above the minimum performance level in measurement year 2022.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for AAH

Based on the overall assessment of AAH's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of AAH's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for AAH show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that AAH followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.

- AAH performed above the high performance levels for the following measures in measurement year 2022:
  - *Childhood Immunization Status—Combination 10*
  - *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - *Immunizations for Adolescents—Combination 2*
  - *Prenatal and Postpartum Care—Postpartum Care*
- HSAG assigned a *High Confidence* level to AAH's 2020–22 *Breast Cancer Screening Among African Americans* Health Equity PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. AAH's member incentive PIP intervention contributed to an increase in the number of members accessing breast cancer screenings, and the MCMC plan determined to adopt the intervention and expand it to additional low-performing providers.
- While HSAG assigned a *Low Confidence* level to AAH's 2020–22 *Child and Adolescent Well-Care Visits (Ages 3 to 21)* PIP, the MCMC plan followed the approved PIP methodology and achieved non-statistically significant improvement in the SMART Aim measure rate.

Opportunities for Improvement

- DHCS identified findings within six of the CFR standards during the DHCS compliance review scoring process for AAH.
- AAH performed below the minimum performance levels in measurement year 2022 for the following five of 15 measure rates that HSAG compared to benchmarks (33 percent):
  - *Cervical Cancer Screening*
  - *Controlling High Blood Pressure—Total*
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Lead Screening in Children*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure AAH meets all CFR standard requirements moving forward.
- For measures for which AAH performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors.

- For the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure, assess whether the provider education and member outreach strategies described in Table C.3 need to be revised to increase the percentage of members turning 15 months old who complete six or more well-child visits.

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

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

Anthem Blue Cross Partnership Plan

Follow-Up on Prior Year Recommendations

Table C.4 provides EQR recommendations HSAG made to Anthem Blue Cross in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.4 to preserve the accuracy of Anthem Blue Cross' self-reported actions.

Table C.4—Anthem Blue Cross' Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Address the findings from the 2021 A&I Medical Audit of Anthem Blue Cross by implementing the actions recommended by A&I.	Anthem Blue Cross was audited by A&I for the following areas: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity. A&I determined deficiencies related to Utilization Management (related to G&A), Case Management and Coordination of Care, Access and Availability of Care, and Administrative and Organizational Capacity. Anthem has completed its CAP related to findings in the Utilization Management, Case Management and Coordination of Care, and Administrative and Organizational Capacity categories. The CAP related to the Access and Availability of Care category is being reviewed by DHCS.

2021–22 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
2. To ensure that its HEDIS Record of Administration, Data Management, and Processes (Roadmap) documentation for supplemental data sources is comprehensive and includes all necessary information prior to submitting for review, Anthem Blue Cross should: a. Continue to implement additional quality control processes to ensure supplemental data are appropriately compiled and available for reporting. b. Develop a flowchart or summary document for its supplemental data sources that identifies the Roadmap attachments which apply to multiple data sources and provide these attachments separately and only once to the auditor to consolidate the documentation and ensure a more efficient review. c. Continue to investigate methods to incorporate supplemental data sources earlier in the audit process to eliminate the review of data sources that are not applicable to the measures and population being audited.	2a. Anthem Blue Cross will continue to implement quality control processes (e.g., meeting with the HSAG auditor earlier regarding expectations for the current HEDIS season, collaborating with our HealthOS team sooner to generate samples specific for each state, working with our data partners to further consolidate and simplify). 2b. Anthem Blue Cross has begun implementing a process Improvement to ensure all supplemental data sources are accurately identified in Section 5 prior to submitting the information to the auditor. The MCMC plan is creating a crosswalk to ensure an efficient review of source names and intake ID from Section 5 to the Supplemental Intake Form, to then match Source Name/Source Name abbreviation to the impact report. 2c. We enhanced our process this year by attempting to eliminate sources that were not applicable. For the upcoming season, we intend to start even earlier and work with our data partners to further consolidate and simplify. We will begin submitting Consolidated Clinical Document Architecture sources for primary source verification in November 2022 for measurement year 2022 with the hope of completing the Consolidated Clinical Document Architecture sources for primary source verification as early as possible. We have a new process to ingest any new certified sources we come across for measurement year 2022 and beyond.

2021–22 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
3. For measures for which Anthem Blue Cross performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Anthem Blue Cross should determine whether interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.	Factors that contributed to the decline in rates from measurement year 2020 to measurement year 2021 were primarily due to the COVID-19 shelter-in-place orders, compounded by the health care emergency California State recommendations. Some provider offices had closed, and Anthem Blue Cross associates were not allowed to enter open facilities to procure medical records. Additionally, to ease the burden on our provider network in 2020–21, Anthem associates were restricted from calling/faxing open offices to request they return medical records due to the stressors the offices were experiencing trying to deal with the health care emergency. California regions were some of the hardest-hit areas in the early stages of the pandemic. For California, the public health emergency was finally closed on February 28, 2023. Actions taken by Anthem Blue Cross during July 1, 2022, through June 30, 2023: ♦ During 2022–23, the Care Delivery Transformation Team regularly met with provider offices. This allowed strategic focus on improving access to services and completion of specific services to improve quality measure rates. Anthem Blue Cross also implemented incentive programs tailored to measures that needed improvement. ♦ During 2022–23, the Member Engagement Team conducted outreach calls to hundreds of thousands of members to remind them of needed services and encourage them to return to the provider offices. Anthem Blue Cross implemented Health Crowd (MPulse) IVR call campaigns with informative/educational messages for

2021–22 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	childhood measures (*Child and Adolescent Well-Care Visits—Total*, *Childhood Immunization Status—Combination 10*, *Immunizations for Adolescents—Combination 2*, and both *Well-Child Visits in the First 30 Months of Life* measures); chronic disease measures (*Controlling High Blood Pressure—Total* and *Hemoglobin A1c [HbA1c] Control for Patients With Diabetes—HbA1c Poor Control [>9.0%]*); and women's health measures (*Breast Cancer Screening—Total*, *Cervical Cancer Screening*, and both *Prenatal and Postpartum Care* measures), with expansion of scope to include member home visits for high utilizers or unresponsive members with chronic illness diagnoses. ♦ During 2022–23, Anthem Blue Cross implemented the Healthy Rewards Program to encourage members to complete needed services for the following measures: ■ Both *Antidepressant Medication Management* measures ■ *Breast Cancer Screening—Total* ■ *Cervical Cancer Screening* ■ *Child and Adolescent Well-Care Visits—Total* ■ *Childhood Immunization Status—Combination 10* ■ *Chlamydia Screening in Women—Total* ■ *Controlling High Blood Pressure—Total* ■ Both *Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication* measures

2021–22 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	■ *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* ■ *Immunizations for Adolescents—Combination 2* ■ Both *Prenatal and Postpartum Care* measures ■ Both *Well-Child Visits in the First 30 Months of Life* measures ♦ During 2022–23, Anthem Blue Cross executed a contract with Cozeva to provide clinics a user-friendly data interface that identifies needed quality care metrics. This tool facilitates timely member-specific information to help clinicians identify services needed to meet compliance for HEDIS measures. So far, provider user engagement has expanded to 99 providers being onboarded.

Assessment of Anthem Blue Cross' Self-Reported Actions

HSAG reviewed Anthem Blue Cross' self-reported actions in Table C.4 and determined that Anthem Blue Cross adequately addressed the 2021–22 EQR recommendations. Anthem Blue Cross indicated that the MCMC plan completed its CAP for all findings from the 2021 A&I Medical Audit, except for the findings in the Access and Availability of Care category. The MCMC plan stated that DHCS is reviewing the CAP for these findings.

For improved performance measure reporting, Anthem Blue Cross provided a detailed description of the process changes the MCMC plan made to ensure that its Roadmap documentation for supplemental data sources is comprehensive and includes all necessary information. Anthem Blue Cross indicated that the continued challenges resulting from COVID-19 contributed to the MCMC plan performing below the minimum performance levels for several measure rates in measurement year 2021. Anthem Blue Cross reported implementing member- and provider-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2021, including:

- Facilitated meetings with provider offices to strategize about how to improve performance measure rates.
- Conducted member outreach calls to remind them to schedule appointments for needed services.
- Implemented a member incentive program.
- Contracted with a vendor to provide a user-friendly data interface to providers.

The interventions Anthem Blue Cross implemented may have contributed to the rates for the following measures moving from below the minimum performance levels in measurement year 2021 to above the minimum performance levels in measurement year 2022:

- *Breast Cancer Screening—Total* for Kings, Madera, and San Benito counties
- *Cervical Cancer Screening* for San Benito County
- *Childhood Immunization Status—Combination 10* for Contra Costa County
- *Chlamydia Screening in Women—Total* for San Benito and San Francisco counties
- *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for Fresno County
- *Immunizations for Adolescents—Combination 2* for Alameda and San Benito counties
- *Prenatal and Postpartum Care—Postpartum Care* for Sacramento County
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* for Alameda and Tulare counties
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* for Alameda, San Benito, Santa Clara, and Tulare counties

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Anthem Blue Cross

Based on the overall assessment of Anthem Blue Cross' delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of Anthem Blue Cross' activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for Anthem Blue Cross show that the MCMC plan was fully compliant with most CFR standards.

- The HSAG auditor determined that Anthem Blue Cross followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- Anthem Blue Cross performed above the high performance levels for the following measures in measurement year 2022:
  - *Chlamydia Screening in Women—Total* for Tulare County
  - *Controlling High Blood Pressure—Total* for Kings County
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* for Kings County, Region 1, Region 2, Sacramento County, San Benito County, and Tulare County
  - *Immunizations for Adolescents—Combination 2* for Madera County
  - *Prenatal and Postpartum Care—Postpartum Care* for Alameda County, Contra Costa County, Region 1, and Tulare County
- Based on its performance measure results across all reporting units, Anthem Blue Cross performed best in San Benito and Tulare counties, where the MCMC plan met or exceeded the minimum performance levels for 12 performance measure rates for each of these reporting units.
- HSAG assigned a *High Confidence* level to Anthem Blue Cross' 2020–22 *Cervical Cancer Screening Among Vietnamese Members* Health Equity PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. Anthem Blue Cross' provider-focused PIP intervention resulted in two clinics making process changes to incorporate into their practices cultural sensitivity and health literacy principles related to well-woman care.
- While HSAG assigned a *Low Confidence* level to Anthem Blue Cross' 2020–22 *Childhood Immunizations* PIP, the MCMC plan followed the approved PIP methodology and achieved non-statistically significant improvement in the SMART Aim measure rate.

Opportunities for Improvement

- DHCS identified findings within three of the CFR standards during the DHCS compliance review scoring process for Anthem Blue Cross.
- Across all reporting units in measurement year 2022, Anthem Blue Cross performed below the minimum performance levels for 84 of the 180 measure rates that HSAG compared to benchmarks (47 percent).
- Performance measure results show that Anthem Blue Cross has opportunities for improvement across all reporting units, with the greatest opportunities for improvement in Fresno County, Region 2, and Contra Costa County, where Anthem Blue Cross performed below the minimum performance levels for 11, 10, and nine performance measure rates, respectively.

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Anthem Blue Cross meets all CFR standard requirements moving forward.
- For measures for which Anthem Blue Cross performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Anthem Blue Cross should determine whether the member- and provider-focused interventions described in Table C.4 need to be revised or abandoned based on intervention evaluation results.

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

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

Blue Shield of California Promise Health Plan

Follow-Up on Prior Year Recommendations

Table C.5 provides EQR recommendations HSAG made to Blue Shield Promise in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.5 to preserve the accuracy of Blue Shield Promise's self-reported actions.

Table C.5—Blue Shield Promise's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Address the findings from the 2022 A&I Medical Audit of Blue Shield Promise by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Utilization Management, Access and Availability of Care, Member's Rights, and Quality Management categories.	CAPs were developed and implemented. The MCMC plan worked closely with DHCS to provide all requested information and updates. DHCS closed the CAPs in March 2023. The subsequent 2023 DHCS Medical Audit demonstrated no repeat deficiencies for Blue Shield Promise.
2. For measures for which Blue Shield Promise performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Blue Shield Promise should determine whether interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.	Blue Shield Promise performed below the minimum performance levels on the following measures in Measurement Year 2021: ♦ *Breast Cancer Screening—Total* ♦ *Cervical Cancer Screening* ♦ *Child and Adolescent Well-Care Visits—Total* ♦ *Immunizations for Adolescents—Combination 2* ♦ Both *Well-Child Visits in First 30 Months of Life* measures The COVID-19 pandemic continued to affect performance on all listed measures. Members remained hesitant to come into the office for

2021–22 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	preventive visits, especially in fall 2021 when COVID-19 rates were high. In addition, providers were exhausted from the 2020–21 COVID-19 year, leading to staff burnout. Provider shortages limited appointment availability, and members had difficulty scheduling timely appointments. Blue Shield Promise implemented a variety of interventions to help address performance on these measures and further support members with getting back into their provider offices for preventive care. **Enhanced Programs from Measurement Year 2022 to Measurement Year 2023** ♦ Mobile Mammography: We have been increasing the number of members served at mobile mammography events each year. We had more mobile mammography events from July 2022 to December 2022 than in 2021. In 2023, we implemented an earlier start of the Mobile Mammography Program, with events scheduled starting in Quarter 1. We developed community partnerships to identify nontraditional locations to hold events and used targeted strategies to identify and outreach to members with the greatest need. ♦ Member Incentives: The Comprehensive Member Incentive Program was launched in Quarter 3 of 2022. Blue Shield Promise implemented an earlier launch of the Comprehensive Member Incentive Program in 2023. Changes to the 2023 program included an increased incentive value for completed well-child visits (members 3 to 21 years old) and cervical cancer screening, and the addition of a human

2021–22 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	papillomavirus (HPV) vaccine member incentive. In addition, we are piloting the use of point-of-care gift cards to improve member engagement for closing care gaps. ♦ Health Navigator Program: Blue Shield Promise conducted a full year of training for health navigators in 2022 and 2023. The program was adjusted in 2023 to realign program goals and revise tracking tools for better oversight on meeting program targets. Health navigators are funded by Blue Shield Promise and embedded within clinics and dedicated to support gap closure for Blue Shield Promise members. ♦ Provider Augmentation: We provide funding to provider groups for blocking schedules for Blue Shield Promise members for after-hours/weekends. We also revised the payment structure to better incentivize providers and improve clinic day outcomes. ♦ Provider Incentive Program: We continued and expanded the Provider Incentive Program by adjusting the weight on earned points to focus on low-performing measures. We included incentives for meeting national benchmarks and/or improvement and reallocated provider incentives into programs that drive improvement. **New Programs Launched in Measurement Year 2023** ♦ Provider Augmentation: Launch of mid-level practitioner provider augmentation program (e.g., nurse practitioner, physician assistant) in members' homes and via telehealth to close care gaps to help with provider capacity.

2021–22 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	♦ Provider Augmentation: Launch of Blue Shield Promise-funded nurse practitioners and physician assistants who work at select target clinics to complete preventive services and close care gaps in the clinic setting to help with provider capacity. ♦ Data Enhancements: Use heat maps to identify geographic areas to target community and provider partnerships to improve key measures such as *Cervical Cancer Screening* and *Well-Child Visits in the First 30 Months of Life*.

Assessment of Blue Shield Promise's Self-Reported Actions

HSAG reviewed Blue Shield Promise's self-reported actions in Table C.5 and determined that Blue Shield Promise adequately addressed the 2021–22 EQR recommendations. Blue Shield Promise indicated that the MCMC plan worked with DHCS to fully resolve all findings from the 2022 A&I Medical Audit and that DHCS closed the CAPs in March 2023.

Blue Shield Promise indicated that the ongoing effects of COVID-19 contributed to the MCMC plan performing below the minimum performance levels for several measure rates in measurement year 2021. Blue Shield Promise reported implementing member- and provider-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2021, including:

- Increased the number of mobile mammography events.
- Offered member incentives.
- Conducted health navigator trainings.
- Offered provider incentives.
- Implemented provider augmentation programs.
- Enhanced use of data to identify priority areas for targeting interventions.

The interventions Blue Shield Promise implemented may have contributed to the rates for the following measures moving from below the minimum performance levels in measurement year 2021 to above the minimum performance levels in measurement year 2022:

- *Breast Cancer Screening—Total*

- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Blue Shield Promise

Based on the overall assessment of Blue Shield Promise's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of Blue Shield Promise's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for Blue Shield Promise show that the MCMC plan was fully compliant with all CFR standards.
- The HSAG auditor determined that Blue Shield Promise followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- Blue Shield Promise performed above the high performance levels for the following measures in measurement year 2022:
  - *Controlling High Blood Pressure—Total*
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
  - *Prenatal and Postpartum Care—Postpartum Care*
- HSAG assigned a *Moderate Confidence* level to Blue Shield Promise's 2020–22 *Childhood Immunizations Among Non-Hispanic Members* Health Equity PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, and documented data to clearly link improvement to at least one tested intervention. Blue Shield Promise's member outreach PIP intervention using a dedicated health navigator contributed to an increase in the number of members completing their recommended vaccinations.
- While HSAG assigned a *Low Confidence* level to Blue Shield Promise's 2020–22 *Well-Child Visits in the First 30 Months of Life* PIP, the MCMC plan followed the approved PIP methodology.

Opportunities for Improvement

- Blue Shield Promise performed below the minimum performance levels in measurement year 2022 for the following five of 15 measure rates that HSAG compared to benchmarks (33 percent):
  - *Cervical Cancer Screening*
  - *Child and Adolescent Well-Care Visits—Total*
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Immunizations for Adolescents—Combination 2*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*

2022–23 External Quality Review Recommendations

- For measures for which Blue Shield Promise performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Blue Shield Promise should determine whether the member- and provider-focused interventions described in Table C.5 need to be revised or abandoned based on intervention evaluation results.

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

In the next annual review, HSAG will evaluate the continued successes of Blue Shield Promise as well as the MCMC plan's progress with this recommendation.

California Health & Wellness Plan

Follow-Up on Prior Year Recommendation

Table C.6 provides the EQR recommendation HSAG made to CHW in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendation. Please note that HSAG made minimal edits to Table C.6 to preserve the accuracy of CHW's self-reported actions.

Table C.6—CHW's Self-Reported Follow-Up on the External Quality Review Recommendation from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendation Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
1. For measures for which CHW performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, CHW should determine whether interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.	Based on intervention evaluation results, CHW continued the implementation initiatives listed below to address the timeliness and quality of services provided to members as noted in the MCMC plan's Quality Work Plan: ♦ Annual HEDIS Unit Family Outreach Initiative: Member outreach focused on live calls with an offer of a warm transfer to the member's PCP to schedule a visit to close care gaps for MCAS measures. ♦ Mobile Mammography: This program partners with providers/clinic sites to expand convenient access to breast cancer screenings via mobile mammography to address barriers and access to care. Equipment (via mobile unit or portable coach) and state-licensed technicians are provided by contracted vendors to conduct the breast cancer screenings. ♦ One-Stop Clinics: One-stop clinics provide clinical care during extended clinic hours (hours outside of a provider's regular business hours or during a set block of time during the week dedicated to CHW members), such as evenings and

2021–22 External Quality Review Recommendation Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	weekends, and can bring additional services on-site to address multiple care gaps at once. ♦ Member Engagement Incentive Program: Point-of-care gift card for members engaging with their providers and accessing care. For 2023, CHW implemented Evaluating Data to Generate Excellence (EDGE), which is a systematic, continuous quality improvement process at the practice and provider group level. We work closely with our Provider Engagement and Medical Affairs Team to address barriers to care and implement specific plans to overcome those barriers.

Assessment of CHW's Self-Reported Actions

HSAG reviewed CHW's self-reported actions in Table C.6 and determined that CHW adequately addressed the 2021–22 EQR recommendations. CHW indicated that based on intervention evaluation results, it continued to implement the following member-focused interventions to improve the MCMC plan's performance on measures for which the plan performed below the minimum performance levels in measurement year 2021:

- Conducted member outreach calls with warm transfers to PCPs to schedule appointments for needed services.
- Expanded mobile mammography sites.
- Implemented one-stop clinics with extended hours of operation.
- Offered point-of-care member incentives.

CHW also implemented a provider-focused continuous quality improvement process.

The interventions CHW implemented may have contributed to the rates for the following measures moving from below the minimum performance levels in measurement year 2021 to above the minimum performance levels in measurement year 2022:

- *Childhood Immunization Status—Combination 10* for Imperial County
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* for Imperial County and Region 1

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CHW

Based on the overall assessment of CHW's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of CHW's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for CHW show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that CHW followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- CHW performed above the high performance levels for the following measures in measurement year 2022:
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* for all three reporting units
  - *Prenatal and Postpartum Care—Postpartum Care* for Imperial County
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Region 1
- Based on its performance measure results across all three reporting units, CHW performed best in Imperial County, where it met or exceeded the minimum performance levels for 10 performance measure rates, compared to six rates each for Region 1 and Region 2.
- While HSAG assigned a *Low Confidence* level to both of CHW's 2020–22 PIPs, the MCMC plan followed the approved PIP methodologies. Additionally, for the *Childhood Immunizations* PIP, CHW achieved the SMART Aim goal.

Opportunities for Improvement

- DHCS identified findings within four of the CFR standards during the DHCS compliance review scoring process for CHW.
- Across all reporting units in measurement year 2022, CHW performed below the minimum performance levels for 23 of the 45 measure rates that HSAG compared to benchmarks (51 percent).
- Performance measure results show that CHW has opportunities for improvement across all three reporting units, with the greatest opportunities for improvement in Region 1 and

Region 2, where CHW performed below the minimum performance levels for nine performance measure rates for each of these reporting units.

2022–23 External Quality Review Recommendations

CHW's contract with DHCS ended December 31, 2023; therefore, HSAG makes no recommendations to the MCMC plan since CHW will not be under contract with DHCS in July 2024 when HSAG requests summaries of how MCMC plans addressed the 2022–23 EQR recommendations. Note that while CHW's contract ends December 31, 2023, DHCS will require the MCMC plan to participate in the measurement year 2023 performance measure validation audit process. HSAG will report CHW's measurement year 2023 performance measure results in the 2023–24 MCMC EQR technical report.

CalOptima

Follow-Up on Prior Year Recommendations

Table C.7 provides EQR recommendations HSAG made to CalOptima in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.7 to preserve the accuracy of CalOptima's self-reported actions.

Table C.7—CalOptima's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Address the findings from the 2022 A&I Medical Audit of CalOptima by implementing the actions recommended by A&I.	The MCMC plan continues to work with DHCS to remediate the 2022 findings. Below is the status of each finding: ♦ Delegation Oversight of Post-Stabilization Authorization (Finding #1.4.1): CAP Remains Open ■ The MCMC plan added post-stabilization authorization oversight to the current Key Performance Indicator dashboard for monitoring and oversight. ♦ Anticipatory Guidance for Lead Exposure (Finding #2.1.1): CAP Accepted ■ The MCMC plan added the Comprehensive Health Assessment Form to the website, developed a blood lead screening refusal form, and provided training to the health networks and providers. ♦ Blood Lead Screening Tests (Finding #2.1.2): CAP Accepted ■ The MCMC plan added the Comprehensive Health Assessment Form to the website, developed a blood lead gap report, updated the provider

2021–22 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	portal with alerts, and conducted training for the health networks and providers. ♦ Physician Certification Statement (PCS) Form Requirements (Finding #3.8.1): CAP Accepted ■ The MCMC plan updated internal desktop requirements, provided training to the health networks, and updated audit tools. ♦ Plan Grievance Resolution Letters (Finding #4.1.1): CAP Accepted ■ The MCMC plan conducted training to staff and hired additional staff members to improve staff-to-case ratios. ♦ Delegated Grievance Resolution Letters (Finding #4.1.2): CAP Accepted ■ The MCMC plan updated the delegation oversight dashboard to include turnaround times to be monitored quarterly for potential CAP issuance and provided training to the health network. The health network implemented daily/quarterly monitoring. ♦ Delegated Grievance Acknowledgement Letters (Finding #4.1.3): CAP Accepted ■ The MCMC plan updated the delegation oversight dashboard to include turnaround times to be monitored quarterly for potential CAP issuance and provided training to the health network. The health network implemented daily/quarterly monitoring. ♦ Quality of Care (QOC) Grievance Medical Director Review (Finding #4.1.6): CAP Accepted ■ The MCMC plan developed new processes to ensure declined potential

2021–22 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	QOC grievances are reviewed by a medical director and provided training to staff. ♦ Quality Improvement Committee Oversight of Utilization Management Activity (Finding #5.1.1): CAP Accepted ■ The MCMC plan developed a process to ensure the quality improvement and utilization management staff members correspond prior to the Quality Improvement Committee meetings, ensuring any compliance issues are discussed at the committee meeting.
2. For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in CalOptima performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors. As part of this assessment, CalOptima should determine whether the member-focused interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.	Due to ongoing low performance measure rates in measurement year 2022, there have been efforts in tandem with the *Well-Child Visits in the First 30 Months of Life* PIP and our current *Well-Child Visits in the First 30 Months of Life* PDSA cycle process as part of our CAP, to perform a root cause and barrier analysis to determine why the rates for both *Well-Child Visits in the First 30 Months of Life* measures were struggling the past few years, especially now since the COVID-19 pandemic has passed, to surpass the MCAS minimum performance level 50th percentile goal. In collaboration with high-volume provider health networks serving our pediatric population, we performed a root cause analysis in the first half of 2023, identifying relevant issues and developing successive strategies for improvement to implement in the remainder of the calendar year. **Issues identified:** ♦ Missing data for visits in the first two months is a major driver for low rates and

2021–22 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	can impact rates by 21 percent. Capturing these data will increase the rate to 70 percent (90th percentile). ♦ A few health networks combined have 93 percent of the two *Well-Child Visits in the First 30 Months of Life* measures' denominators (one health network has almost 60 percent). Improvement in rates to the 66th percentile for these groups will increase overall *Well-Child Visits in the First 30 Months of Life* measure rates to well above the minimum performance levels. ♦ Missed opportunities for converting sick visits to well-child visits is at 29 percent. Other challenges: ♦ Currently, only three health networks submit supplemental data. The impact of supplemental data on overall rates for measurement year 2022 is 8 percent. ♦ NCQA Quality Compass thresholds continue to increase each year, which means rates need to demonstrate sustained year-over-year improvement in order to meet the minimum performance levels. **Strategy 1**: Data capture for newborn visits billed under mother's client identification number (CIN). **Strategy:** Engage with providers to encourage use of newborn codes for well-care visits in the first 28 days of life. Submission of newborn well-child visit codes billed under the mother's CIN allows data to be linked to the newborn using the family link.

2021–22 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	Goal: Educate providers on best practices for conducting and coding for well-child visits including newborn well-child visits. **Anticipated Outcomes:** Increase identification and data capture of newborn well-child visits billed under mother's CIN, which will positively impact the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure rate. **Deliverables:** A "Well-Child Visits Best Practice Guide" will be shared via communication channels (provider updates, health network weekly communications, etc.). **Strategy 2:** Early Medi-Cal Enrollment of Newborns **Strategy:** Promote early Medi-Cal enrollment of newborns through outreach to pregnant members and new moms in collaboration with community partners and providers. **Goal:** Improve health care for newborns and infants. **Anticipated Outcome:** Improve access to newborn well-care visits and improve data capture for newborn visits. **Deliverables:** ♦ Establish community and clinic partnerships to promote well-child visits for the newborn and early Medi-Cal enrollment. ♦ Distribute "Early Medi-Cal Enrollment Supports Newborn Care" flyer to high-volume obstetrician and pediatric providers. **Strategy 3:** Supplemental Data Submission

2021–22 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	Strategy: Collaborate with all health networks to ensure supplemental data are submitted throughout the year. **Goal:** Establish a best practice data reconciliation and supplemental data sharing process with health networks. **Outcome:** Close additional data gaps which will positively impact HEDIS rates. **Deliverables:** ♦ Enhancements to monthly health network gap report. ♦ Share supplemental data template with all health networks. ♦ Recommend all health networks to submit supplemental data. Activities already completed in 2023 to support these efforts include: ♦ Live call campaigns to *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure noncompliant list. ♦ First and second birthday card reminders. ♦ Text message campaigns. ♦ Health guide 0 to 2 years newsletter mailings. ♦ Member newsletter articles. ♦ Targeted mailings with well-child visit flyers. ♦ IVR robocall campaigns. ♦ Development of *Well-Child Visits in the First 30 Months of Life* measure member detailed gap reports for health network distribution.

Assessment of CalOptima's Self-Reported Actions

HSAG reviewed CalOptima's self-reported actions in Table C.7 and determined that CalOptima adequately addressed the 2021–22 EQR recommendations. CalOptima provided detailed information about the status of each finding from the 2022 A&I Medical Audit and indicated that the MCMC plan is working with DHCS to fully resolve all findings.

To determine the factors contributing to the MCMC plan performing below the minimum performance levels for both *Well-Child Visits in the First 30 Months of Life* measures in measurement year 2021, CalOptima performed a root cause analysis in collaboration with high-volume provider health networks and provided a description of identified issues and challenges. CalOptima also summarized the strategies the MCMC plan implemented to address the identified issues and challenges. Strategies included member- and provider-focused interventions, including:

- Worked with providers to ensure accurate data capture for services provided and sharing of supplemental data across the health networks.
- Conducted member outreach in collaboration with community partners and providers.

The interventions CalOptima implemented may have contributed to the rates for both *Well-Child Visits in the First 30 Months of Life* measures moving from below the minimum performance levels in measurement year 2021 to above the minimum performance levels in measurement year 2022.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CalOptima

Based on the overall assessment of CalOptima's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of CalOptima's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for CalOptima show that the MCMC plan was fully compliant with all but one of the 14 CFR standards.
- The HSAG auditor determined that CalOptima followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.

- CalOptima performed above the high performance levels for the following measures in measurement year 2022:
  - *Chlamydia Screening in Women—Total*
  - *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - *Immunizations for Adolescents—Combination 2*
- HSAG assigned a *High Confidence* level to both of CalOptima's 2020–22 PIPs, reflecting that the MCMC plan followed the approved PIP methodologies, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. CalOptima's PIP interventions resulted in expanded access to mammograms for Chinese and Korean members and improved care gap data sharing processes with a select provider that resulted in more eligible members being seen for their well-child visits.

Opportunities for Improvement

- DHCS identified findings within one of the CFR standards during the DHCS compliance review scoring process for CalOptima.
- CalOptima performed below the minimum performance level in measurement year 2022 for the *Lead Screening in Children* measure.

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure CalOptima meets all CFR standard requirements moving forward.
- Assess the factors that contributed to CalOptima performing below the minimum performance level in measurement year 2022 for the *Lead Screening in Children* measure and implement quality improvement strategies that target the identified factors.

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

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

CalViva Health

Follow-Up on Prior Year Recommendations

Table C.8 provides EQR recommendations HSAG made to CalViva in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.8 to preserve the accuracy of CalViva's self-reported actions.

Table C.8—CalViva's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Address the findings from the 2022 A&I Medical Audit of CalViva by implementing the actions recommended by A&I.	**Finding 2.1.1: Provision of Blood Lead Screening of Young Children; and** **Finding 2.1.2: Provision of Anticipatory Guidance for Lead Exposure and Lead Poisoning:** CalViva has continued efforts to improve results and enhance processes associated with the provision of blood lead screening for members ages 12 to 72 months in Fresno, Kings, and Madera counties since the 2022 A&I Medical Audit through the following interventions: ♦ Conducted ongoing provider monitoring of performance of blood lead level screenings, and provision of anticipatory guidance to parents/caregivers has continued in Fresno, Kings, and Madera counties. CalViva reported results and analyses quarterly to the Quality Improvement/Utilization Management Committee and the California Rental Housing Association Commission. ♦ Sent letters to providers identified as not meeting the requirements for lead screening and anticipatory guidance to

2021–22 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	reiterate the lead screening policy and provider responsibilities. ♦ Identified appropriate Current Procedural Terminology (CPT) codes (consistent with DHCS) for provider documentation of the provision of anticipatory guidance related to lead poisoning as a component of preventive medicine counseling. The MCMC plan added these codes to the CalViva Health Childhood Blood Lead Screening Policy, outlining their use in the documentation of anticipatory guidance in the member record. ♦ Updated and enhanced provider training materials to include policy updates and the availability of an on-demand format with attestation to document completed trainings. ♦ Conducted routine communication of best practices to provider office staff to include a focus on blood lead screening, with trainings at regular intervals when trouble-shooting performance issues or when new staff members are hired at the office/clinic. ♦ Updated the Provider Tip Sheet on Childhood Blood Lead Screening to address the use of CPT codes to document the provision of anticipatory guidance as well as the requirement to document anticipatory guidance and/or member refusal. **Finding 3.8.1: Physician Certification Statement** CalViva implemented the following procedures to ensure that a completed PCS Form is received from providers before NEMT services are provided:

2021–22 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	♦ Developed a new transportation-specific oversight policy and desktop and PCS Form flow chart designed to effectively monitor the receipt of the PCS Form from providers, and diligently followed up with providers who do not submit the PCS Form in a timely manner. For nonresponding providers, this process includes escalation processes to both CalViva's provider relations and provider network management teams to directly engage the providers. ♦ Monitoring: The MCMC plan's transportation broker provides daily oversight of the PCS process and provides the MCMC plan with daily reports of PCS Form receipts. ♦ Auditing: The MCMC plan's Vendor Oversight Team audits the PCS Form process through quarterly transportation scorecard reviews and reporting. ♦ A summary of these and other transportation oversight activities is reviewed by CalViva's management via a new Quarterly Transportation Oversight Report.
2. For measures for which CalViva performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, CalViva should determine whether interventions the plan previously implemented need to be	Medical management staff members performed an assessment of the factors that affected CalViva's performance targeting low-performing metrics in 2021, including COVID-19, in order to implement quality improvement strategies addressing these factors. A review of this process resulted in the identification of three strategies targeting different HEDIS measures that were implemented to mitigate the impact of COVID-19:

2021–22 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
revised or abandoned based on intervention evaluation results.	1. Antidepressant Medication Management Outreach—Kings and Madera counties 2. Medication Adherence Pharmacy Outreach Program—Diabetes/Hypertension—Fresno and Madera counties 3. Pediatric Household Outreach—Fresno, Kings, and Madera counties The following two strategies were abandoned in 2022: ♦ The Antidepressant Medication Management Outreach strategy used live-call outreach to CalViva members in Kings and Madera counties who were prescribed an antidepressant medication, diagnosed with major depression, and showing gaps in their antidepressant medication refills between 15 and 50 days. These live outreach calls supported medication adherence and provided additional resources to members with depression. The top barriers included unwanted side-effects and forgetting to take medication. When members were contacted, they were appreciative and agreeable to follow-up calls, but low engagement rates (22 percent) indicated that this is a difficult-to-reach population and that the intervention was resource-intensive with low benefit. The MCMC plan determined to consider alternate interventions. ♦ The Medication Adherence Pharmacy Outreach Program targeted members with diabetes and hypertension in Fresno and Madera counties (members with HbA1c >9 percent and/or uncontrolled hypertension). The pharmacist used motivational interviewing techniques to understand the individual barriers to compliance and help with medication adherence through dialogue

2021–22 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	and by contacting the member's pharmacy and/or provider when needed to address identified issues. Low engagement rates (18 percent to 26 percent) were also identified for this intervention. This intervention was discontinued in February 2022 due to limited impact on clinical improvement for the diabetes and hypertension HEDIS measures. CalViva is currently exploring other options that would make the pharmacy outreach more effective, such as collaborative practice agreements with providers that would allow the pharmacist to change a member's prescription without a new prescription from the physician. CalViva is currently evaluating recent successes, considering future opportunities for quality improvement projects and interventions in 2023–26, and prioritizing these efforts within the DHCS domains. In partnership with DHCS, CalViva plans to modify the third strategy and address it through quality improvement activities in the domain of pediatric care: ♦ The Pediatric Household Outreach strategy targeted the child and adolescent population with live calls to contact households with multiple pediatric care gaps in all three CalViva counties to improve chlamydia screening rates (anchor) and all additional household pediatric gaps in care, including well-child visits, blood lead screening, topical fluoride, and childhood and adolescent immunizations. Due to the delay caused by script development and approval, this strategy was not implemented. CalViva plans to implement interventions to address this population impacted by COVID-19 within the Children's Health domain.

Assessment of CalViva's Self-Reported Actions

HSAG reviewed CalViva's self-reported actions in Table C.8 and determined that CalViva adequately addressed the 2021–22 EQR recommendations. CalViva provided detailed descriptions of the actions the MCMC plan has taken to address each finding from the 2022 A&I Medical Audit. CalViva indicated that the continued challenges resulting from COVID-19 contributed to the MCMC plan performing below the minimum performance levels for several measure rates in measurement year 2021. CalViva described strategies the MCMC plan implemented and the status of each, including rationale for abandoning interventions that were ineffective.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CalViva

Based on the overall assessment of CalViva's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of CalViva's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for CalViva show that the MCMC plan was fully compliant with all but one of the CFR standards.
- The HSAG auditor determined that CalViva followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- CalViva performed above the high performance levels for the following measures in measurement year 2022:
  - *Controlling High Blood Pressure—Total* for Kings County
  - *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for Kings County
  - *Immunizations for Adolescents—Combination 2* for Madera County
  - *Prenatal and Postpartum Care—Postpartum Care* for all three reporting units
- Based on its performance measure results across all three reporting units, CalViva performed best in Madera County, where it met or exceeded the minimum performance levels for 13 performance measure rates compared to nine rates for Kings County and seven rates for Fresno County.

- HSAG assigned a *High Confidence* level to both of CalViva's 2020–22 PIPs, reflecting that the MCMC plan followed the approved PIP methodologies, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. CalViva's PIP interventions resulted in expanded access to mammograms for Hmong-speaking members and improved access to immunizations for members turning 2 years of age who had not yet completed all recommended doses.

Opportunities for Improvement

- DHCS identified findings within one of the CFR standards during the DHCS compliance review scoring process for CalViva.
- Across all reporting units in measurement year 2022, CalViva performed below the minimum performance levels for the following 16 of 45 measure rates that HSAG compared to benchmarks (36 percent):
  - *Cervical Cancer Screening* for Fresno County
  - *Child and Adolescent Well-Care Visits—Total* for Fresno and Kings counties
  - *Childhood Immunization Status—Combination 10* for Fresno and Kings counties
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* for Fresno and Madera counties
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* for Fresno and Madera counties
  - *Immunizations for Adolescents—Combination 2* for Kings County
  - *Lead Screening in Children* for Fresno and Kings counties
  - Both *Well-Child Visits in the First 30 Months of Life* measures for Fresno and Kings counties
- Performance measure results across all three reporting units show that CalViva has the greatest opportunities for improvement in Fresno and Kings counties based on the MCMC plan performing below the minimum performance levels for eight and six performance measure rates, respectively, compared to two rates for Madera County.

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure CalViva meets all CFR standard requirements moving forward.
- For measures for which CalViva performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors.
  - Based on measurement year 2022 performance measure results, CalViva should prioritize implementing quality improvement strategies in Fresno and Kings counties.

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

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

CenCal Health

Follow-Up on Prior Year Recommendations

Table C.9 provides EQR recommendations HSAG made to CenCal in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.9 to preserve the accuracy of CenCal's self-reported actions.

Table C.9—CenCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Assess whether the member education and provider incentive strategies the plan previously implemented to improve chlamydia screening rates need to be revised or abandoned based on CenCal's performance for the *Chlamydia Screening in Women—Total* measure remaining below the minimum performance level in measurement year 2021 for San Luis Obispo County.	For measurement year 2022 reporting, CenCal surpassed the minimum performance level for the *Chlamydia Screening in Women—Total* measure in both Santa Barbara and San Luis Obispo counties. For San Luis Obispo County, the rate improved more than 6 percentage points from the measurement year 2021 rate. CenCal implemented member education and provider incentive strategies that will continue and have been expanded due to improvements achieved from the most recent measurement period. <u>Member Educational Intervention</u> CenCal implemented a digital educational intervention program that encouraged members to discuss the importance of chlamydia screening in addition to other sexually transmitted infections (STIs) with their PCP. CenCal partnered with a large FQHC in San Luis Obispo County to test this digital

2021–22 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	educational campaign in October 2021 and continued testing through September 2022. This educational video has been promoted to all PCPs. Below is the Web address for these videos (Know More: STIs), which are available on YouTube. English: https://youtu.be/NT6rwkUTkWU Spanish: https://youtu.be/jBaMMazegxk <u>Provider Incentive Intervention</u> CenCal implemented a P4P program, Quality Care Incentive Program, to provide financial incentives to health care providers with excellence in clinical care for MCMC plan members. Chlamydia screening was included as an incentivized measure. Through this program, PCPs receive monthly gaps-in-care lists to identify members due for screenings. Through focused quality collaboratives as part of CenCal's PDSA cycle process with the same large FQHC with which it piloted the Know More educational video campaign, the PCP site has realized significant improvements. To increase efficiencies, CenCal staff members worked with the FQHC information technology staff to transmit gaps-in-care lists for all Quality Care Incentive Program incentivized measures via a secure file transfer protocol site. The FQHC information technology staff created customized reports for their internal team to perform member outreach and education on the importance of completing this clinically recommended service. The reports contain all necessary member information for the provider and clinical staff. CenCal continues to monitor the intervention through the Chlamydia Screening PDSA cycle process.

2021–22 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	The intervention being tested via PDSA cycles has significantly helped CenCal to surpass the DHCS-required minimum performance level. A third PDSA cycle will continue through October 2023.
2. For both reporting units, assess the factors, which may include COVID-19, that resulted in CenCal performing below the minimum performance level for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure in measurement year 2021 and implement quality improvement strategies that target the identified factors.	CenCal identified a variety of factors that may have contributed to the rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure being below the minimum performance level, including but not limited to: ♦ Provider knowledge of members due for preventive care. ♦ Provider and member knowledge regarding preventive care screening frequency requirements as recommended by the American Academy of Pediatrics Periodicity Schedule. ♦ Provider knowledge of billing code requirements. ♦ Availability of provider incentives. CenCal implemented a PDSA cycle process as part of the quality accountability requirements, with the goal to increase the rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure in both Santa Barbara and San Luis Obispo counties to at least surpass the minimum performance level. CenCal's primary intervention to support improvements for this aspect of care included focused quality collaborative meetings to help with practice transformation. Because of the amount of funding available to PCPs to improve this aspect of care, CenCal was able to realize significant improvements. For measurement year 2022, this aspect of care

2021–22 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	surpassed the required DHCS minimum performance level. As part of the PDSA cycle process, CenCal partnered with a high-volume, low-performing PCP site. Through this partnership, it was identified that an actionable gaps-in-care list would help the clinic's system to identify members due for preventive services. This was critical as PCPs lacked a system to identify children falling behind the American Academy of Pediatrics Periodicity Schedule. Once developed, the system was made available to CenCal's entire PCP network through the MCMC plan's secure provider portal. The report's purpose is to aid PCPs with prioritization of outreach calls to ensure members receive the clinically recommended preventive services. The report incorporates encounter data from supplemental data sources, including data provided by DHCS and CenCal claims data. To support the knowledge gap of preventive care, CenCal also informs members of the importance of preventive care screenings. CenCal's P4P program helped the MCMC plan surpass the DHCS-required minimum performance level for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure in both Santa Barbara and San Luis Obispo counties for measurement year 2022.

Assessment of CenCal's Self-Reported Actions

HSAG reviewed CenCal's self-reported actions in Table C.9 and determined that CenCal adequately addressed the 2021–22 EQR recommendations. CenCal described the member education and provider incentive interventions that the MCMC plan implemented to address the rate for the *Chlamydia Screening in Women—Total* measure for San Luis Obispo County being below the minimum performance level in measurement year 2021. CenCal indicated that the interventions the MCMC plan tested via PDSA cycles contributed to the rate for the *Chlamydia Screening in Women—Total* measure for San Luis Obispo County moving to above the minimum performance level in measurement year 2022.

CenCal described the factors the MCMC plan identified that may have contributed to CenCal performing below the minimum performance levels in measurement year 2021 for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure for both reporting units. To address these factors, CenCal implemented a PDSA cycle process in both reporting units to help providers with practice transformation to support process changes that would result in outreach to members due for their well-child visits. CenCal indicated that the intervention it tested via the PDSA cycle process contributed to the MCMC plan performing above the minimum performance level for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure for both reporting units in measurement year 2022.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CenCal

Based on the overall assessment of CenCal's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of CenCal's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for CenCal show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that CenCal followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- CenCal performed above the high performance levels for the following measures in measurement year 2022:

- *Breast Cancer Screening—Total* for Santa Barbara County
- *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* for both reporting units
- *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for both reporting units
- *Immunizations for Adolescents—Combination 2* for Santa Barbara County
- *Prenatal and Postpartum Care—Postpartum Care* for both reporting units
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* for Santa Barbara County

- HSAG assigned a *High Confidence* level to both of CenCal's 2020–22 PIPs, reflecting that the MCMC plan followed the approved PIP methodologies, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions.
  - CenCal's *Postpartum Care for Members Residing in San Luis Obispo County* Health Equity PIP interventions resulted in improved provider identification of members who need a postpartum visit scheduled, which contributed to an increase in the number of members being seeing for a postpartum visit within the recommended time frame.
  - CenCal's *Well-Child Visits in the First 15 Months of Life* PIP intervention contributed to improvement in members being seen for their well-child visits within the recommended time frame and the MCMC plan making systemwide changes within its PCP network to support members being seen in a timely manner for their well-child visits.

Opportunities for Improvement

- DHCS identified findings within four of the CFR standards during the DHCS compliance review scoring process for CenCal.
- Across both reporting units in measurement year 2022, CenCal performed below the minimum performance levels for the following five of 30 measure rates that HSAG compared to benchmarks (17 percent):
  - *Controlling High Blood Pressure—Total* for both reporting units
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* for Santa Barbara County
  - *Lead Screening in Children* for both reporting units

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure CenCal meets all CFR standard requirements moving forward.
- For measures for which CenCal performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors.

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

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

Central California Alliance for Health

Follow-Up on Prior Year Recommendation

Table C.10 provides the EQR recommendation HSAG made to CCAH in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendation. Please note that HSAG made minimal edits to Table C.10 to preserve the accuracy of CCAH's self-reported actions.

Table C.10—CCAH's Self-Reported Follow-Up on the External Quality Review Recommendation from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendation Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
1. For measures for which CCAH performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. a. As part of this assessment, CCAH should determine whether the member- and provider-focused strategies the plan previously implemented to improve breast cancer and chlamydia screening rates were implemented differently in Monterey/Santa Cruz counties than in Merced County based on CCAH's performance for the *Breast Cancer Screening—Total* and *Chlamydia Screening in Women—Total* measures improving in Monterey/Santa Cruz counties and remaining below the minimum	HEDIS performance in measurement year 2021 was impacted by the pandemic, with clinics focused on COVID-19 vaccinations for the first half of the year and catch-up preventive care in the second half of the year. Several clinics continued to experience challenges due to the members refusing care and feeling uncomfortable to leave their homes. Clinics also experienced a decrease in staffing due to COVID-19 illnesses, burnout, needing full-time childcare, and staff members not wanting to receive mandated COVID-19 vaccinations. Some clinics were running with half the staff that they had prior to the pandemic. Telehealth also provided considerable challenges with members' access to and understanding of technology. Planning for quality improvement activities was scaled down based on continued dialogue with our clinics about feasibility, with a focus on resuming care campaigns for members. The allowance to choose the data collection methodology for performance measure reporting has provided flexibility for HEDIS

2021–22 External Quality Review Recommendation Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
performance levels in measurement year 2021 in Merced County.	measure planning related to choosing resources and medical record chase decisions. For behavioral health data, a gap was identified early this year, improving previous poor performance for the two *Follow-Up After Emergency Department Visit for Mental Illness* measures. Based on feedback received and close work with our DHCS nurse consultant, SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis activities determined that provider-focused strategies should be enacted to increase breast cancer and chlamydia screening rates. Multiple providers agreed to partake in outreaching members to perform member recall. In addition, Black members have been preselected in Merced County for outreach, and letters and informatics from the United States Preventive Services Task Force will be sent to members, notifying them of disease statistics and to contact their PCPs for the appropriate screening services. Providers who performed below the 50th percentile in 2022 also were able to apply by May 2023 for a quality improvement project to make sustained improvements in staffing, processes, and technology for prioritized HEDIS measures. The MCMC plan sees no difference between implementation of strategies between counties, but rather sees a difference in the barriers experienced by members residing in each of the counties. Barriers include provider shortages, including ancillary support, economic and social variances, and issues related to transportation. CCAH is actively working to create unique strategies by county to account for the differing landscapes.

2021–22 External Quality Review Recommendation Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	SWOT analysis activities for pediatric measures include a peer provider training through a Merced County provider champion, as well as a member barrier analysis through phone outreach for well-child visits in the first 15 months. SWOT performance as well as PIPs demonstrated performance which far exceeded established goals. As with any performance project, the MCMC plan determines the feasibility of wider implementation among its provider population. Through CCAH's robust Provider Incentive Program, which provides reporting to providers on quality performance and works to ensure collaboration with providers to provide overall MCAS improvement efforts, the MCMC plan works to ensure that all measures with rates below the minimum performance levels are an area of focus. As outlined in prior submissions, CCAH's 2022–26 Strategic Plan works to create a health-equitable and person-centered delivery system in collaboration with communities and providers.

Assessment of CCAH's Self-Reported Actions

HSAG reviewed CCAH's self-reported actions in Table C.10 and determined that CCAH adequately addressed the 2021–22 EQR recommendation. For measures for which CCAH performed below the minimum performance levels in measurement year 2021, the MCMC plan indicated that COVID-19 was a contributing factor. CCAH indicated that being able to choose the data collection methodology resulted in the MCMC plan being better able to plan for performance measure reporting. CCAH worked with providers to conduct member outreach to improve breast cancer and chlamydia screening rates, and CCAH implemented peer provider training and a member barrier analysis via phone outreach to improve the MCMC plan's performance on pediatric measures. CCAH noted that it identified differences by county in the barriers experienced by members, and the MCMC plan is actively working to create county-specific strategies to address these barriers.

The peer provider training and a member barrier analysis via phone outreach strategies CCAH implemented may have contributed to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure rate moving from below the minimum performance level in measurement year 2021 to above the minimum performance level in measurement year 2022 for Monterey/Santa Cruz counties.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CCAH

Based on the overall assessment of CCAH's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of CCAH's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for CCAH show that the MCMC plan was fully compliant with all CFR standards.
- The HSAG auditor determined that CCAH followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- CCAH performed above the high performance levels for the following measures in measurement year 2022:
  - *Childhood Immunization Status—Combination 10* for Monterey/Santa Cruz counties
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* for Monterey/Santa Cruz counties
  - *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for Monterey/Santa Cruz counties
  - *Immunizations for Adolescents—Combination 2* for Monterey/Santa Cruz counties
  - *Prenatal and Postpartum Care—Postpartum Care* for Monterey/Santa Cruz counties
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Merced County
- Based on its performance measure results, CCAH performed better in Monterey/Santa Cruz counties, where it met or exceeded the minimum performance levels for 15 performance measure rates compared to seven rates for Merced County.
- HSAG assigned a *High Confidence* level to CCAH's 2020–22 *Child and Adolescent Well-Care Visits Among Members Residing in Merced County* Health Equity PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and

accurately summarized the key findings and conclusions. CCAH's provider-focused and member outreach interventions contributed to an increase in completed well-care visits.

- HSAG assigned a *Moderate Confidence* level to CCAH's 2020–22 *Childhood Immunizations* PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, and documented data to clearly link improvement to at least one tested intervention. CCAH's member incentive PIP intervention contributed to an increase in the number of eligible members receiving their first or second flu vaccine, and the MCMC plan's immunization registry PIP intervention resulted in all registry data issues being resolved.

Opportunities for Improvement

- CCAH performed below the minimum performance levels in measurement year 2022 for the following eight of the 30 measure rates that HSAG compared to benchmarks (27 percent), with all rates being for Merced County:
  - *Breast Cancer Screening—Total*
  - *Child and Adolescent Well-Care Visits—Total*
  - *Childhood Immunization Status—Combination 10*
  - *Chlamydia Screening in Women—Total*
  - *Immunizations for Adolescents—Combination 2*
  - *Lead Screening in Children*
  - Both *Well-Child Visits in the First 30 Months of Life* measures
- Performance measure results show that CCAH has the greatest opportunities for improvement in Merced County based on the MCMC plan performing below the minimum performance levels for eight performance measure rates for this reporting unit compared to zero rates for Monterey/Santa Cruz counties.

2022–23 External Quality Review Recommendations

- For measures for which CCAH performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, CCAH should determine whether the member- and provider-focused interventions described in Table C.10 need to be revised or abandoned based on intervention evaluation results.

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

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

Community Health Group Partnership Plan

Follow-Up on Prior Year Recommendation

Table C.11 provides the EQR recommendation HSAG made to CHG in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendation. Please note that HSAG made minimal edits to Table C.11 to preserve the accuracy of CHG's self-reported actions.

Table C.11—CHG's Self-Reported Follow-Up on the External Quality Review Recommendation from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendation Directed to CHG	Self-Reported Actions Taken by CHG during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
1. For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in CHG performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors.	The root cause of the factors that resulted in CHG not achieving the minimum performance level in measurement year 2021 for both *Well-Child Visits in the First 30 Months of Life* measures was the COVID-19 pandemic. Pandemic-related issues and barriers included: ♦ Shelter-in-place orders that were in place for nearly 15 months during the period when children born between July 5, 2018, through October 2, 2020, should have received well-child visits. (This is the period when children who turned 15 or 30 months of age during measurement year 2021 would have been born.) ♦ The Executive Order plus fear of COVID-19 prevented Californians from seeking routine, preventive care. ♦ Providers were impacted by staffing challenges and having to implement social distancing and safe office protocols. These protocols limited the number of patients who could be seen in the office. ♦ The schools were closed, and parents were caring for their children. Many had to stay

2021–22 External Quality Review Recommendation Directed to CHG	Self-Reported Actions Taken by CHG during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	home to care for their children, impacting the staffing at provider offices. ♦ Due to social distancing protocols, parents were not able to bring other children to providers' offices, limiting the ability to seek health care. ♦ Providers' offices closed or reduced hours as they dealt with staffing challenges and the financial impact of COVID-19. ♦ During the period when California implemented the Blueprint for a Safer Economy in response to the COVID-19 pandemic, San Diego County was in either the purple or red tier for seven months during the period of September 2020 through March 2021, a key period overlapping the time frame when well visits for measurement year 2021 should have occurred. To mitigate some of the impact related to the pandemic, CHG: ♦ Promoted telehealth visits (including video conferencing, telephone consultation, and e-consults) and provided instructions on submitting claims for these services among PCPs and specialists. The first message was sent out in March 2022, and it was repeated throughout the pandemic. ♦ Notified providers of all HEDIS measures that allowed the use of telehealth visits to count toward a positive score in July 2020, immediately after NCQA released the HEDIS 2020 standards. ♦ Informed members about the availability of telehealth visits and how to seek care during the pandemic. ♦ Worked with the American Academy of Pediatrics of San Diego and Imperial counties, the County of San Diego Health

2021–22 External Quality Review Recommendation Directed to CHG	Self-Reported Actions Taken by CHG during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	and Human Services Agency, and the Healthy San Diego Health Education and Cultural and Linguistics Workgroup to support and distribute the "Pediatric Provider Toolkit—Caring for Children During the COVID-19 Public Health Emergency." ♦ Implemented provider and member incentives to increase the number of wellness visits. ♦ Conducted outreach calls and helped members with scheduling appointments. ♦ Conducted monthly check-in meetings with providers regarding their performance on MCAS measures, with an emphasis on well visits and immunizations. In November 2022, CHG completed a SWOT analysis for both *Well-Child Visits in the First 30 Months of Life* measures as part of a quality improvement project with DHCS. In January 2023, CHG developed three strategies and six action items (two action items per strategy) based on the SWOT analysis: 1. Strategy #1: Increase the knowledge about and the importance of wellness visits among parents/guardians. a. Action #1: Hired outreach specialists to conduct targeted outreach to members, educate members on preventive services, schedule appointments, and address barriers. Subpopulations wherein the well-child visit rate is lower than the aggregate rate are prioritized in the outreach efforts. b. Action #2: Developed a New Parent Handbook that has been translated into all threshold languages and is being used in outreach activities.

2021–22 External Quality Review Recommendation Directed to CHG	Self-Reported Actions Taken by CHG during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	2. Strategy #2: Work with selected high-volume obstetricians/gynecologists (OB/GYNs) to connect CHG's outreach workers with parents/guardians. a. Action #1: Identified community health worker partners to focus on prenatal and postpartum services and to include newborn care, with a focus on preventive services, screening, and vaccinations. b. Action #2: Based on a curriculum developed by CHG and a community health worker partner, appropriately train and certify community health workers. The curriculum includes the American Academy of Pediatrics Bright Futures periodicity schedule and recommendations, including blood lead screening and immunizations. 3. Strategy #3: Provide member and provider incentives to support the completion of well visits. a. Action #1: Develop member incentives to include the completion of well-child visits counting toward both *Well-Child Visits in the First 30 Months of Life* measures. b. Action #2: Develop provider incentives to include the completion of well-child visits counting toward both *Well-Child Visits in the First 30 Months of Life* measures. Provider incentives align with member incentives and support outreach activities.

Assessment of CHG's Self-Reported Actions

HSAG reviewed CHG's self-reported actions in Table C.11 and determined that CHG adequately addressed the 2021–22 EQR recommendation. CHG summarized COVID-19-related factors that contributed to the MCMC plan performing below the minimum performance levels for both *Well-Child Visits in the First 30 Months of Life* measures in measurement year 2021. Additionally, CHG reported implementing member- and provider-focused interventions to improve performance on both measures, including:

- Promoted telehealth visits with providers and notified providers of performance measures for which telehealth visits contribute to the rates.
- Informed members about telehealth visit availability.
- Offered member and provider incentives for completion of well-child visits.
- Conducted outreach calls and helped members schedule appointments.
- Hired outreach specialists who prioritized efforts to reach subpopulations with the lowest well-child visit rates.
- In collaboration with a community health worker partner, trained and certified community health workers.

The interventions CHG implemented may have contributed to the rates for both *Well-Child Visits in the First 30 Months of Life* measures moving from below the minimum performance levels in measurement year 2021 to above the minimum performance levels in measurement year 2022.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CHG

Based on the overall assessment of CHG's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of CHG's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for CHG show that the MCMC plan was fully compliant with most CFR standards.

- The HSAG auditor determined that CHG followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- CHG performed above the high performance level in measurement year 2022 for the *Breast Cancer Screening—Total* measure.
- HSAG assigned a *High Confidence* level to CHG's 2020–22 *Adolescent Well-Care Visits (Ages 12 to 17)* PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. CHG's multi-mode member outreach and incentive PIP intervention contributed to an increase in the number of eligible members being seen for a well visit.
- HSAG assigned a *Moderate Confidence* level to CHG's 2020–22 *Cervical Cancer Screening Among Black/African-American Members* Health Equity PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, and documented data to clearly link improvement to at least one tested intervention. CHG's multi-mode member outreach and incentive PIP intervention contributed to an increased number of eligible Black/African-American members receiving a cervical cancer screening.

Opportunities for Improvement

- DHCS identified findings within five of the CFR standards during the DHCS compliance review scoring process for CHG.
- CHG performed below the minimum performance level in measurement year 2022 for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure.

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure CHG meets all CFR standard requirements moving forward.
- Assess the factors that contributed to CHG performing below the minimum performance level in measurement year 2022 for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure and implement quality improvement strategies that target the identified factors.

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

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

Contra Costa Health Plan

Follow-Up on Prior Year Recommendations

Table C.12 provides EQR recommendations HSAG made to CCHP in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.12 to preserve the accuracy of CCHP's self-reported actions.

Table C.12—CCHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Continue to work with DHCS to fully resolve all findings from the 2020 A&I Medical Audit of CCHP.	CCHP continues to ensure compliance with the corrective actions to remediate the findings from the 2020 A&I Medical Audit. Regarding 1.2.1, CCHP utilization management team receives automatic updates from its non-Medi-Cal criteria and receives ad hoc utilization management updates from CCHP's compliance team. Those Medi-Cal updates from CCHP's compliance team are discussed at the Compliance Fraud Subcommittee meeting. The updates, if any, are further discussed at Utilization Management Committee meetings to ensure all personnel are aware of the updates. Regarding 1.2.2, CCHP continues to train and monitor its utilization management personnel to ensure compliance with authorization time frames. CCHP has greatly improved its compliance with authorization requests. Regarding 1.2.3, CCHP updated its "Your Rights" attachment, and the attachment is now

2021–22 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	automatically included in utilization management communications, as appropriate. Regarding 1.3.1, CCHP updated its desktop policy to include prompt communications to the member regarding appeals, including informing members of the limited time to present evidence or testimony in person or in writing sufficiently in advance of the appeal resolution for expedited appeals. Regarding 1.3.2, CCHP used Medi-Cal criteria, as appropriate, as the basis of utilization management determinations. Regarding 1.5.1, CCHP updated its memorandum of understanding (MOU) with a table that clearly delineates the utilization management responsibilities and specific delegated functions and activities of the MCMC plan and delegate. Regarding 1.5.2, CCHP no longer requires authorization for mental health services. Regarding 1.5.3, CCHP requires its delegate to use CCHP's utilization management policies and criteria for all delegated utilization management decision making. The delegate has 24/7 access to these policies and criteria that CCHP updates regularly. Regarding 2.1.1, CCHP updated its assessment to ensure that the appropriate questions were used to stratify members.

2021–22 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	Regarding 2.1.2, CCHP, with help from a vendor, now is compliant with health risk assessment (HRA) timelines. Regarding 2.1.3, CCHP, with help from a vendor, now performs regular outreach to members for HRA stratification, as appropriate. Regarding 2.1.4, CCHP utilizes the DHCS tool and guidance to appropriately stratify members based on their responses. Regarding 2.1.5, CCHP, with help from a vendor, provides the member the DHCS tool to stratify members, as appropriate. Regarding 2.1.6, CCHP is compliant with developing individualized care plans for those members identified as high risk based on the HRA results. Regarding 2.1.7, CCHP continues to work with its providers to ensure that all recommended services are completed and documented. Providers are reminded of these requirements regularly, including at Quality Council meetings, through quarterly trainings, via provider newsletters, in email communications, and via website resources. Finally, CCHP includes these requirements in its facility site review process. Regarding 2.5.1, CCHP's MOU was updated to include a mutually agreed-upon review process for timely resolution of clinical and administrative disputes regarding mental health and other covered services.

2021–22 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	Regarding 2.5.2, CCHP's utilization management policies have been updated to provide which mental health services its primary care physicians can provide. The policies are updated and approved by DHCS, as appropriate. Regarding 3.1.1, CCHP's Quality Department updated its policies to include positive pregnancy tests obtained out of network. Regarding 3.1.2, CCHP's Quality and Compliance departments, with the help of a vendor, are compliant with monitoring wait times at providers' offices and wait times to answer and return phone calls. These evaluations are performed at least annually and reported to DHCS as required. Regarding 3.5.1, CCHP updated its internal claims systems to ensure that interest was paid with any late payments of emergency services claims. Regarding 3.5.2, CCHP updated its internal claims procedures to ensure that family planning claims were not denied based on other services submitted on the claim. Regarding 3.8.1, CCHP now requires that written consent forms be obtained for unaccompanied minors requiring NEMT and nonmedical transportation (NMT) services. These forms are stored by CCHP in the member's electronic health record (EHR).

2021–22 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	Regarding 3.8.2, CCHP requires that PCS forms be required for all NEMT services. Regarding 3.8.3, CCHP requires that all NEMT providers be enrolled with DHCS in order to provide services. Regarding 4.1.1, CCHP has updated its policies and desktop procedures and retrained all personnel to ensure that grievances are fully addressed. Furthermore, CCHP performs audits of its grievances to ensure they are addressed appropriately. Regarding 4.1.2, CCHP has updated its desktop procedures and retrained its personnel to ensure that grievances are classified as appropriate. This includes classifying exempt and standard grievances. Regarding 4.1.3, CCHP has updated its desktop procedures and retrained its personnel to ensure that grievances are classified as appropriate. Regarding 4.1.4, CCHP has updated its desktop procedures and retrained its personnel to ensure that grievances pertaining to QOC are referred to the medical director, as appropriate. Regarding 4.1.5, CCHP has updated its desktop procedures and retrained its personnel to ensure that grievances are classified as appropriate.

2021–22 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	Regarding 4.1.6, CCHP reports all grievances to its Quality Council at least quarterly. Regarding 4.1.7, CCHP's compliance team investigates, packages, and submits all grievances alleging discrimination to DHCS within 10 calendar days of a resolution letter. Regarding 4.2.1, CCHP's Quality Department, in conjunction with the Quality Council, have developed and implemented a process to ensure the population needs assessment addresses the needs of the children with special health care needs population. Regarding 4.3.1, CCHP has worked extensively with Contra Costa County to obtain background checks and fingerprint scanning for all outstanding employees. Only one person remains who is on leave. Regarding 5.1.1, CCHP updated is desktop procedures to ensure that all investigations are thoroughly investigating. Investigation reports are funneled up to the reviewing providers, who review the case in its entirety to ensure appropriate completion. Regarding 5.1.2, CCHP updated its MOUs to ensure clear delegation of potential quality issue (PQI) requirements. Regarding 5.2.1, CCHP continues to work with its delegates to obtain the necessary information.

2021–22 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	Regarding 5.3.1, CCHP updated its policies and procedures to ensure that new provider training is conducted within 10 working days of being placed on active status. Regarding 5.3.2, CCHP updated its new provider communications to clarify expectations regarding new provider training. Regarding 6.1.1, CCHP updated its MOUs to specify the responsibility of health education services to provide and evaluate health education services. Regarding 6.2.1, CCHP updated its policies to ensure that all suspected cases of fraud, waste, and abuse are reported within 10 business days. Regarding 6.2.2, CCHP updated its policies and procedures to ensure all reported cases are appropriately investigated.
2. Address the findings from the 2021 A&I Medical and State Supported Services Audits of CCHP by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Member's Rights and Quality Management categories.	Regarding 1.2.1, CCHP updated the Notice of Action (NOA) templates. Regarding 1.2.2, CCHP's utilization management team performed retraining of its providers to ensure that a clear explanation was included for the NOAs. The team also performed quarterly evaluations to ensure compliance. Regarding 2.1.1, CCHP corrected the HRA form to ensure long-term services and supports questions were no longer used in classifying members as high risk.

2021–22 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	Regarding 2.1.2, CCHP now includes provider information materials that indicate CCS reimburses only CCS-paneled providers and CCS-approved hospitals within its network, and only from the date of the referral. Regarding 3.6, CCHP has updated its claims systems to distribute add-on payments for specified family planning services claims as required under All Plan Letter (APL) 20-013. Regarding 4.3.1, CCHP has worked extensively with Contra Costa County to obtain background checks and fingerprint scanning for all outstanding employees. Only one person remains who is on leave. Regarding 5.1.1, CCHP now ensures that its governing body reviews and approves the quality improvement program description, workplan, and program evaluation. Regarding 5.1.2, CCHP updated its MOUs to ensure clear delegation of PQI requirements. Regarding 5.3.1, CCHP has updated its agreements with its providers to clarify the assigned provider training responsibilities. Regarding 5.3.2, CCHP has updated its agreements with its providers to clarify the assigned provider training responsibilities.
3. For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in CCHP performing below the minimum performance levels for	CCHP believes the following factors likely contributed to our performance for both *Well-Child Visits in the First 30 Months of Life* measures:

2021–22 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors.	♦ COVID-19 Pandemic: The ongoing COVID-19 pandemic led to disruptions in health care systems worldwide. Many families were hesitant to visit health care facilities due to concerns about exposure to the virus, resulting in missed or delayed appointments, including well-child visits. CCHP believes the COVID-19 pandemic to be the largest contributor to our below-normal performance on both rates. In fact, CCHP's 2022 performance increased by 11.53 percentage points for members 31 days to 15 months of age and 8.47 percentage points for members ages 15 to 30 months. This improved performance is also remarkable when considering the eligible population increased by 4.4 percent for members ages 31 days to 15 months and 22.3 percent for members ages 15 to 30 months, when comparing to the 2020 eligible population. ♦ Telehealth Limitations: While telehealth services expanded during the pandemic, certain aspects of well-child visits, such as physical examinations, vaccinations, and growth measurements, require in-person visits. The limitations of telehealth might have hindered parents from scheduling complete well-child visits for their children. ♦ School Closures and Disruptions: There is a seasonality to well-child visits, with a high number of visits occurring just before the start of the school year. School closures and disruptions caused by the pandemic may have affected children's routines and access to health care services.

2021–22 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	CCHP implemented the following actions/strategies to increase well-child visit completion rates in the target population: ♦ Collaborated with provider groups on automated messages sent by the EHR. ■ CCHP worked with our largest provider group in implementing a series of messages to parents, encouraging well-child visits. These pushes have been extremely successful. Since implementation, 20 percent of parents make an appointment within a few days of receiving the text message. ♦ Coordinated with clinics on direct patient outreach and promoting incentives, including via telephonic outreach and mailed materials. ■ CCHP coordinated with clinic quality teams to implement direct calls to parents to increase appointment uptake. Direct calls have resulted in 22 percent of all patients called (and 40 percent of all patients reached) making an appointment. ♦ Developed recurring meetings with providers to discuss quality scores and general trends post-COVID-19. ■ These provider meetings have given a regular cadence to discuss quality and help customize strategies with individual providers.

Assessment of CCHP's Self-Reported Actions

HSAG reviewed CCHP's self-reported actions in Table C.12 and determined that CCHP adequately addressed the 2021–22 EQR recommendations. CCHP provided detailed descriptions of the steps the MCMC plan has taken to address the findings from the 2020 and 2021 A&I audits. CCHP summarized the factors that contributed to the MCMC plan performing below the minimum performance levels for both *Well-Child Visits in the First 30 Months of Life*

measures in measurement year 2021, including the continued effects of COVID-19. CCHP reported implementing provider-focused interventions to improve performance on both measures, including:

- Collaborated with provider groups to send automated outreach messages to members via the EHR.
- Coordinated with clinics to conduct outreach calls via phone to promote incentives, provide educational materials, and schedule needed appointments.
- Met regularly with providers to discuss quality scores and post-COVID-19 trends.

The interventions CCHP implemented may have contributed to the rates for both *Well-Child Visits in the First 30 Months of Life* measures moving from below the minimum performance levels in measurement year 2021 to above the minimum performance levels in measurement year 2022.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for CCHP

Based on the overall assessment of CCHP's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of CCHP's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for CCHP show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that CCHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- CCHP performed above the high performance levels for the following measures in measurement year 2022:
  - *Breast Cancer Screening—Total*
  - *Cervical Cancer Screening*
  - *Immunizations for Adolescents—Combination 2*
  - Both *Prenatal and Postpartum Care* measures
- HSAG assigned a *High Confidence* level to both of CCHP's 2020–22 PIPs, reflecting that the MCMC plan followed the approved PIP methodologies, achieved improvement,

documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. CCHP's care management PIP intervention contributed to improved HbA1c levels for members diagnosed with diabetes, and the MCMC plan's member outreach PIP intervention facilitated access to well-care visits for Black/African-American members 3 to 6 years of age and resulted in an increase in completed well-care visits for these members.

Opportunities for Improvement

- DHCS identified findings within six of the CFR standards during the DHCS compliance review scoring process for CCHP.
- CCHP performed below the minimum performance levels in measurement year 2022 for the following two of 15 measure rates that HSAG compared to benchmarks (13 percent):
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Lead Screening in Children*

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure CCHP meets all CFR standard requirements moving forward.
- For measures for which CCHP performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors.

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

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

Gold Coast Health Plan

Follow-Up on Prior Year Recommendations

Table C.13 provides EQR recommendations HSAG made to GCHP in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.13 to preserve the accuracy of GCHP's self-reported actions.

Table C.13—GCHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Improve monitoring and oversight processes for the MCMC plan's encounter data to ensure that all encounter data are included for performance measure reporting.	GCHP monitors monthly submissions for consistent encounter volumes, and to determine when the complete data are expected to be provided, will contact the provider when an expected submission is not received or if there is a major variance in volume compared to prior months. The encounter data issue that occurred in early 2022 stemmed from one newly delegated vendor that had challenges with submitting encounter data. However, the issue was resolved by April 2022, and the vendor's encounter data were received and included in the April 2022 administrative data refresh for reporting the measurement year 2021 MCAS rates.
2. Assess whether the member- and provider-focused strategies the plan previously implemented to improve breast cancer and chlamydia screening rates need to be revised or abandoned based on GCHP's performance for the *Breast Cancer Screening—Total* and *Chlamydia Screening in Women—Total*	**Measurement Year 2022 Performance** GCHP's rate for the *Breast Cancer Screening—Total* measure improved more than 3 percentage points compared to measurement year 2021, meeting the minimum performance level for measurement year 2022.

2021–22 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
measures remaining below the minimum performance levels in measurement year 2021	GCHP's rate for the *Chlamydia Screening in Women—Total* measure decreased by 0.2 percentage points from measurement year 2021 to measurement year 2022 and did not meet the minimum performance level. **<u>Previously Tested Strategies</u>** The below strategies to improve breast cancer and chlamydia screenings were implemented based on measurement year 2021 findings and subsequently evaluated for effectiveness. ♦ **Meeting with clinics to pair age-appropriate women's health screenings:** This intervention was revised to be solely focused on providing training for chlamydia screening, and the narrative was tailored to highlight the connection between chlamydia screening and adolescent well-care visits. ♦ **GCHP-clinic system co-branded mammogram postcard:** This intervention was abandoned due to the health system not having the bandwidth to complete this task. ♦ **In-person/virtual provider training on chlamydia screening best practices:** These trainings were well received by individual providers. Due to their success and requests by large provider groups for further training, this intervention was expanded to two large health systems and the local Comprehensive Perinatal Services Program. Additionally, GCHP hosted a lunch and learn as documented in the "New Strategies" listed below. ♦ **Address health disparities caused by cultural and linguistic barriers:** This intervention was adopted. A health education flyer and frequently asked questions (FAQ) document were created

2021–22 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	and tested for cultural appropriateness and translated into threshold languages to target the disparity. The flyer and FAQ documents were posted to the GCHP website and handed out to provider and community partners. **<u>New Strategies for July 1,2022–June 30, 2023</u>** **Intervention Strategy:** Engage providers in quality improvement activities to improve chlamydia screening rates. ♦ We met with low-performing providers to share measurement year 2021 rates and discuss barriers and best practices to increase chlamydia screening rates. ♦ We hosted a virtual lunch and learn on improving chlamydia screening. GCHP hosted 60 provider attendees and presented about why it is important to screen for chlamydia in the 16- to 24-year-old female population as well as best practices. GCHP also shared appropriate materials to help facilitate screening. ♦ Clinic level chlamydia screening rates were shared at monthly meetings with quality improvement teams at affiliated health systems. **Intervention Strategy:** Engage providers in quality improvement activities to improve breast cancer screening rates. ♦ We partnered with a local hospital-based breast cancer center to implement a point-of-care member incentive program for breast cancer screening. So far, the program has handed out more than 70 $40 gift cards.

2021–22 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	♦ We conducted a training with GCHP's Care Management and Utilization Management teams on the *Breast Cancer Screening—Total* and *Chlamydia Screening in Women—Total* performance measures to provide resources and best practices when speaking with members and how to refer to providers.
3. For the *Child and Adolescent Well-Care Visits—Total* and both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in GCHP performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors.	GCHP completed a barrier analysis for measurement year 2021 and found that factors such as COVID-19, lack of education of members and/or providers, limited access to care, and discrepancies with internal data sources resulted in GCHP performing below the minimum performance levels for the *Child and Adolescent Well-Care Visits—Total* and both *Well-Child Visits in the First 30 Months of Life* measures. Quality strategies that were implemented included ongoing member birthday mailings to remind members to go in for a well-child visit, provider trainings on the importance of timely well-child visits, and data improvement activities. In measurement year 2022, we achieved the minimum performance level for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure and improved our rate by 7.7 percentage points. Although we did not meet the minimum performance level for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure, we did improve our rate from measurement year 2021 by 26.26 percentage points. The rate for the *Child and Adolescent Well-Care Visits—Total* measure improved by 8.4 percentage points from measurement year 2021; however, we did not meet the 50th

2021–22 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	percentile for this measure in measurement year 2022. A barrier analysis for measurement year 2022 performance is in progress, and interventions will be implemented based on barrier analysis findings.

Assessment of GCHP's Self-Reported Actions

HSAG reviewed GCHP's self-reported actions in Table C.13 and determined that GCHP adequately addressed the 2021–22 EQR recommendations.

GCHP described the process it uses to ensure all encounter data are included for performance measure reporting and confirmed that issues present in 2022 with one of its vendors have been resolved.

GCHP summarized interventions the MCMC plan previously tested to improve performance on the *Breast Cancer Screening—Total* and *Chlamydia Screening in Women—Total* measures and indicated whether GCHP had abandoned, adapted, or adopted the interventions. GCHP also described new interventions the MCMC plan implemented to improve performance on these measures. GCHP focused the new interventions on engaging providers in quality improvement activities to improve breast cancer and chlamydia screening rates.

GCHP indicated that it conducted a barrier analysis to determine the factors contributing to the MCMC plan performing below the minimum performance levels in measurement year 2021 for the *Child and Adolescent Well-Care Visits—Total* and both *Well-Child Visits in the First 30 Months of Life* measures. GCHP determined that factors included COVID-19, member and provider lack of education, limited member access to care, and MCMC plan data issues. GCHP implemented the following interventions to address the identified factors:

- Mailed cards to members to remind them to schedule their well-child visits.
- Conducted provider trainings.
- Made improvements to data processes.

The interventions GCHP implemented may have contributed to the rates for the *Breast Cancer Screening—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measures moving from below the minimum performance levels in measurement year 2021 to above the minimum performance levels in measurement year 2022.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for GCHP

Based on the overall assessment of GCHP's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of GCHP's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for GCHP show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that GCHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- GCHP performed above the high performance levels in measurement year 2022 for both *Prenatal and Postpartum Care* measures.
- HSAG assigned a *High Confidence* level to both of GCHP's 2020–22 PIPs, reflecting that the MCMC plan followed the approved PIP methodologies, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. GCHP's member outreach and incentive PIP intervention, which included offering Saturday clinics, improved access to cervical cancer screenings for eligible members and resulted in an increase in the number of members receiving their cervical cancer screenings. The MCMC plan's member incentive outreach and care gap PIP interventions contributed to an increase in the number of eligible members completing their well-care exams.

Opportunities for Improvement

- DHCS identified findings within four of the CFR standards during the DHCS compliance review scoring process for GCHP.
- GCHP performed below the minimum performance levels in measurement year 2022 for the following four of 15 measure rates that HSAG compared to benchmarks (27 percent):
  - *Child and Adolescent Well-Care Visits—Total*
  - *Chlamydia Screening in Women—Total*
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*

- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure GCHP meets all CFR standard requirements moving forward.
- For measures for which GCHP performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, GCHP should determine whether the member- and provider-focused interventions described in Table C.13 to improve well-child visit, well-care visit, and chlamydia screening rates need to be revised or abandoned based on intervention evaluation results.

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

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

Health Net Community Solutions, Inc.

Follow-Up on Prior Year Recommendations

Table C.14 provides EQR recommendations HSAG made to Health Net in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.14 to preserve the accuracy of Health Net's self-reported actions.

Table C.14—Health Net's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Continue to work with DHCS to fully resolve all findings from the 2021 A&I Medical Audit of Health Net.	**Access and Availability of Care** The MCMC plan required the transportation vendor to create a policy and remediation plan to address the enrollment status of NMT and NEMT providers. The vendor was also required to create a remediation plan to terminate non-enrolled providers from the vendor's network. Enhanced oversight and monitoring reports/tools allow Health Net to monitor the progress. **Member's Rights** The MCMC plan revised its procedure to categorize 100 percent of expressions of dissatisfaction related to a QOC issue as a grievance. QOC letter templates were revised to ensure consistent language to support clear and concise explanations of Health Net's decision as well as training to reduce the reading level of medical decisions.

2021–22 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
2. Address the findings from the 2022 A&I Medical Audit of Health Net by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Access and Availability of Care and Member's Rights categories.	**Utilization Management** The MCMC plan integrated utilization management activity data into the Quality Improvement Strategy, specifically for dental anesthesia. Health Net updated its policies to include a formalized reporting structure of the dental anesthesia outcomes and data to the Health Net Utilization Management Quality Improvement Committee. Prior Authorization Decisions: The MCMC plan implemented daily monitoring to track inventory on a real-time basis to ensure required turnaround times are being met, including a monthly random sampling of cases to ensure letters are sent in a timely manner. Utilization Review Criteria, Pharmacist License: The MCMC plan revised processes to clarify procedures related to interrater reliability testing and retesting. Two California-licensed registered pharmacists have been hired to review prior authorizations for Health Net. Only California-licensed pharmacists are reviewing prior authorizations as of March 1, 2023. Delegation of Utilization Management Oversight of Prior Authorization Process: During 2022, Health Net engaged in longstanding and ongoing collaboration with the Los Angeles County Department of Health Services and L.A. Care to address the Los Angeles County Department of Health Services' eConsult system. Health Net worked with the two organizations to ensure appropriate decision making and that member communication, including communication about appeal rights, is issued to members within the utilization management process.

2021–22 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	Through this collaborative process, specific reporting has been created as well as enhanced oversight and auditing activities to ensure the Los Angeles County Department of Health Services is meeting all regulatory and turnaround time requirements. This work is ongoing. **Case Management and Coordination of Care** CCS Coordination: Health Net created reports to identify all members with new or existing CCS conditions in order to perform outreach for purposes of case management and care coordination services. Behavioral Health Treatment Plan: Health Net created an applied behavioral analysis treatment plan checklist for case managers to use when reviewing treatment plans to confirm that services are no longer medically necessary under Early and Periodic Screening, Diagnostic, and Treatment, including the criteria utilized to make that determination. Continuity of Care with an Out of Network Provider and Notification to Members: Health Net updated policies and procedures to address the gap in identifying what qualifies for continuity of care with an out-of-network provider. The MCMC plan implemented training and monitoring to ensure continuity of care decisions are made correctly. **Access and Availability of Care** PCS (repeat finding), Enrollment of NEMT/NMT Providers: Health Net implemented additional oversight and

2021–22 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	monitoring, including a quarterly scorecard review, to address missing PCS forms. Reporting and tracking were created to identify providers who were not enrolled with DHCS in order to remove them from the network. **Member's Rights** QOC Letters (repeat finding): Health Net conducted training on the QOC and letter writing process to address this finding. The MCMC plan sought guidance from DHCS with respect to the level of information that could be included in the letters while still maintaining confidentiality of the Peer Review Committee. Those recommendations are being implemented to address this finding.
3. For measures for which Health Net performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Health Net should determine whether interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.	Based on intervention evaluation results, Health Net continued implementing the initiatives listed below to address timeliness and quality of services provided to members as noted in the MCMC plan's Quality Work Plan: ♦ Annual HEDIS Unit Family Outreach Initiative: Member outreach focused on live calls with an offer of a warm transfer to the member's PCP to schedule a visit to close care gaps for MCAS measures. ♦ Mobile Mammography: This program partners with providers/clinic sites to expand convenient access to breast cancer screenings via mobile mammography to address barriers and access to care. Equipment (via mobile unit or portable coach) and state-licensed technicians are provided by contracted vendors to conduct the breast cancer screenings. ♦ One-Stop Clinics: One-stop clinics provide clinical care during extended clinic hours (hours outside of a provider's regular

2021–22 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	business hours or during a set block of time during the week dedicated to Health Net members), such as evenings and weekends, and can bring additional services on-site to address multiple care gaps at once. ♦ Member Engagement Incentive Program: Point-of-care gift card for members engaging with their providers and accessing care. For 2023, Health Net implemented EDGE, which is a systematic, continuous quality improvement process at the practice and provider group level. We work closely with our Provider Engagement and Medical Affairs Team to address barriers to care and implement specific plans to overcome those barriers.

Assessment of Health Net's Self-Reported Actions

HSAG reviewed Health Net's self-reported actions in Table C.14 and determined that Health Net adequately addressed the 2021–22 EQR recommendations. Health Net described in detail the actions the MCMC plan has taken to address all findings from the 2021 and 2022 A&I Medical Audits.

Health Net indicated that based on intervention evaluation results, it continued implementing the following member-focused interventions to improve the MCMC plan's performance on measures for which the plan performed below the minimum performance levels in measurement year 2021 and to address the timeliness and quality of services provided to members:

- Conducted member outreach calls with warm transfers to PCPs to schedule appointments for needed services.
- Expanded mobile mammography sites.
- Implemented one-stop clinics with extended hours of operation.
- Offered point-of-care member incentives.

Health Net also implemented a provider-focused continuous quality improvement process.

The interventions Health Net implemented may have contributed to the rates for the following measures moving from below the minimum performance levels in measurement year 2021 to above the minimum performance levels in measurement year 2022:

- *Breast Cancer Screening—Total* for Los Angeles County
- *Controlling High Blood Pressure—Total* for Sacramento and San Joaquin counties
- *Immunizations for Adolescents—Combination 2* for Los Angeles County
- *Prenatal and Postpartum Care—Postpartum Care* for Los Angeles and San Joaquin counties
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Los Angeles and Sacramento counties

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Health Net

Based on the overall assessment of Health Net's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of Health Net's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for Health Net show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that Health Net followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- Health Net performed above the high performance levels for the following measures in measurement year 2022:
  - *Cervical Cancer Screening* for Tulare County
  - *Chlamydia Screening in Women—Total* for Los Angeles County
  - *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* for Tulare County
- Based on its performance measure results across all reporting units, Health Net performed best in Tulare County, where the MCMC plan met or exceeded the minimum performance levels for 11 performance measure rates.

- HSAG assigned a *High Confidence* level to both of Health Net's 2020–22 PIPs, reflecting that the MCMC plan followed the approved PIP methodologies, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions.
  - Health Net's *Breast Cancer Screening Among Russian Members in Sacramento County* Health Equity PIP care coordination intervention contributed to improvement in breast cancer screening rates among the target population.
  - Health Net's *Childhood Immunizations* PIP member outreach intervention contributed to eligible members scheduling appointments and receiving needed immunizations.

Opportunities for Improvement

- DHCS identified findings within three of the CFR standards during the DHCS compliance review scoring process for Health Net.
- Across all reporting units in measurement year 2022, Health Net performed below the minimum performance levels for 66 of the 105 measure rates that HSAG compared to benchmarks (63 percent).
- Performance measure results show that Health Net has opportunities for improvement across all reporting units, with the greatest opportunities for improvement in Kern, Stanislaus, and San Joaquin counties, where Health Net performed below the minimum performance levels for 14, 14, and 11 performance measure rates, respectively.

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Health Net meets all CFR standard requirements moving forward.
- For measures for which Health Net performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Health Net should determine whether the member- and provider-focused interventions described in Table C.14 need to be revised or abandoned based on intervention evaluation results.
  - Based on measurement year 2022 performance measure results, Health Net should prioritize implementing quality improvement strategies in Kern, San Joaquin, and Stanislaus counties.

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

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

Health Plan of San Joaquin

Follow-Up on Prior Year Recommendations

Table C.15 provides EQR recommendations HSAG made to HPSJ in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.15 to preserve the accuracy of HPSJ's self-reported actions.

Table C.15—HPSJ's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Address the findings from the 2021 A&I Medical Audit of HPSJ by implementing the actions recommended by A&I.	**Oversight of Grievances** Changed the process to have data loss prevention staff members guide the process. Only clinical staff review QOC grievances, and a medical director reviews all QOC concerns. **Training Medical Directors and Peer Review Training** The chief medical officer trains and onboards new medical directors, and G&A staff members train medical directors on PQI processes and documentation. Beginning October 2022, quarterly meetings are held to review G&A and to remediate opportunities. **Quality Improvement Staff Training** HPSJ conducts thorough 1:1 orientation of new hires on G&A and PQI processes, systems, and internal departments. HPSJ provides real-time feedback on deficiencies and holds weekly tag-up meetings as provider training refreshers on end-to-end G&A processes.

2021–22 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	Reviews and Audits Starting Sept 2022, HPSJ implemented audits to determine effective and accurate scoring, decisions, documentation, and escalations to the chief medical officer and the Peer Review and Credentialing Committee. **Escalation Processes** Changes in leveling and case escalation, referrals to the medical directors, and all PQIs that are referred to the Peer Review and Credentialing Committee are reviewed by the chief medical officer and discussed with the quality improvement team and medical directors prior to review by the Peer Review and Credentialing Committee.
2. To ensure the MCMC plan fully understands the medical record requirements, review the hybrid measure specifications early in the audit process and implement additional validations for the hybrid measures.	HPSJ contracted with a highly reputable HEDIS hybrid specification training vendor to augment existing plan processes. The vendor provided comprehensive training on the technical specifications for hybrid review. HPSJ trained all additional internal and external temporary staff through a train-the-trainer methodology. HPSJ enforced higher standards for attendance and quality assurance, which helped with logistical implementation of the hybrid review project. Training for temporary HEDIS staff members included HEDIS specification quizzes as well as in-depth tests that included chart abstraction. In measurement year 2022, HPSJ passed medical record review validation with no findings or issues.

2021–22 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
3. For measures for which HPSJ performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, HPSJ should determine whether interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.	**PIPs** ♦ Improve well-child visit rates for members ages 12 to 21 years using direct scheduling by HPSJ. The PIP demonstrated statistically significant programmatic improvement, and the MCMC plan is expanding the intervention to all interested providers. ♦ Improve cervical cancer screening rates for White women in Stanislaus County by using reminder outreach calls. The PIP did not demonstrate statistically significant outcomes, and HPSJ abandoned the intervention. **PDSAs—Health Equity** Interventions for noted measures consisted of heavy outreach to members/parents with and without direct scheduling. HPSJ provided health education related to the measures, help with translation and transportation, and incentives. The MCMC plan conducted follow-up with members who missed or cancelled appointments. During the intervention implementation, the team adapted the process to include more focus on members receiving services that count toward the measures' rates and less focus on follow-up calls. PDSA—HPSJ abandoned using the prenatal subcategory. PDSA—HPSJ adapted the chlamydia screening intervention and is still actively implementing it. SWOT—HPSJ experienced challenges with provider partners and operational system changes, which proved to be a hinderance to the SWOT progress.

Assessment of HPSJ's Self-Reported Actions

HSAG reviewed HPSJ's self-reported actions in Table C.15 and determined that HPSJ adequately addressed the 2021–22 EQR recommendations. HPSJ described in detail the actions the MCMC plan has taken to address all findings from the 2021 A&I Medical Audit. To ensure HPSJ understands medical record review requirements, the MCMC plan contracted with a vendor to provide comprehensive training to HPSJ staff members on the technical specifications for hybrid review. The MCMC plan reported having no issues with medical record review processes during the measurement year 2022 performance measure audit process.

HPSJ reported implementing member-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2021, including:

- Scheduled needed appointments for members.
- Conducted member outreach to provide educational materials, help with translation and transportation services, and offer incentives.
- Conducted follow-up with members who missed or cancelled their appointments.

The interventions HPSJ implemented may have contributed to the rate for the *Childhood Immunization Status—Combination 10* measure for San Joaquin County moving from below the minimum performance level in measurement year 2021 to above the minimum performance level in measurement year 2022.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for HPSJ

Based on the overall assessment of HPSJ's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of HPSJ's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for HPSJ show that the MCMC plan was fully compliant with most CFR standards.

- The HSAG auditor determined that HPSJ followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- HSAG assigned a *High Confidence* level to HPSJ's 2020–22 *Adolescent Well-Care Visits (Ages 12 to 21)* PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. HPSJ's member outreach PIP intervention contributed to an increase in the number of well-care visits scheduled and completed.
- While HSAG assigned a *Low Confidence* level to HPSJ's 2020–22 *Cervical Cancer Screening Among White Members Residing in Stanislaus County* Health Equity PIP, the MCMC plan followed the approved PIP methodology.

Opportunities for Improvement

- DHCS identified findings within four of the CFR standards during the DHCS compliance review scoring process for HPSJ.
- Across both reporting units in measurement year 2022, HPSJ performed below the minimum performance levels for 20 of the 30 measure rates that HSAG compared to benchmarks (67 percent).

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure HPSJ meets all CFR standard requirements moving forward.
- For measures for which HPSJ performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors.

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

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

Health Plan of San Mateo

Follow-Up on Prior Year Recommendations

Table C.16 provides EQR recommendations HSAG made to HPSM in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.16 to preserve the accuracy of HPSM's self-reported actions.

Table C.16—HPSM's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Address the findings from the 2021 A&I Medical Audit of HPSM by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Quality Management category.	As stated in the *Strengths* section of the 2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for HPSM, "A&I identified no findings during the 2021 State Supported Services Audit of HPSM." However, A&I issued HPSM one finding for 5.2.1 Ownership and Disclosure Forms. HPSM sought to confirm legal interpretation of the disclosure form requirements through DHCS' Managed Care Quality Monitoring, Medical Audit CAP Compliance division. Subsequently, HPSM required its delegates to provide updated and completed ownership and disclosure forms.
2. For measures for which HPSM performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this	HPSM performed below the minimum performance levels in measurement year 2021 for the *Cervical Cancer Screening* and both *Well-Child Visits in the First 30 Months of Life* measures. To improve these measures' rates, HPSM implemented a three-cycle PDSA project for the *Cervical Cancer Screening* measure and a SWOT analysis and action

2021–22 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
assessment, HPSM should determine whether interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.	plan for the *Well-Child Visits in the First 30 Months of Life* measures. Following is a summary of the interventions for the first two PDSA cycles: ♦ The intervention for cycle 1 of the *Cervical Cancer Screening* measure PDSA was conducting data validation with Coastside Clinic to address the priority barrier of data reconciliation. This intervention was abandoned as no further action was needed. ♦ The intervention for cycle 2 of the *Cervical Cancer Screening* measure PDSA was conducting outreach calls to Black/African-American members identifying with or who have developmental disabilities and are managed by Golden Gate Regional Center. The priority barriers addressed were members being unaware of the need for screening, members having misconceptions about screening, and members not attending general preventive health visits where screening would be initiated. This intervention was adopted for the remainder of the year. The strategies adopted for the *Well-Child Visits in the First 30 Months of Life* measures based on the SWOT analysis were: ♦ Create a permanent, continuous Child and Youth Health Population Workgroup to improve the rates for the two *Well-Child Visits in the First 30 Months of Life* measures, lead screening rates, and other preventive care measure outcomes. ♦ Leverage established rapport with providers to provide updates regarding capillary test availability and care gap

2021–22 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	reports related to the *Well-Child Visits in the First 30 Months of Life* measures and lead screening compliance. ♦ Leverage relationship and the existing agreement with the county's Family Home Visiting Program. ♦ Explore the feasibility of a member incentive initiative for the *Well-Child Visits in the First 30 Months of Life* measures. ♦ HPSM will implement these strategies with corresponding action items through 2023 and will conduct an assessment at the end of the year to determine which items will be abandoned, adapted, or adopted.

Assessment of HPSM's Self-Reported Actions

HSAG reviewed HPSM's self-reported actions in Table C.16 and determined that HPSM adequately addressed the 2021–22 EQR recommendations. HPSM described the steps it took to address the repeat findings A&I identified in the Quality Management category during the 2021 A&I Medical Audit of HPSM.

To address the MCMC plan performing below the minimum performance level in measurement year 2021 for the *Cervical Cancer Screening* measure, HPSM implemented a PDSA project to test member- and provider-focused interventions. To address performance being below the minimum performance levels in measurement year 2021 for both *Well-Child Visits in the First 30 Months of Life* measures, HPSM reported conducting a SWOT analysis that resulted in the MCMC plan partnering with community organizations and providers to improve member compliance for well-child visits. The MCMC plan is also exploring the feasibility of offering a member incentive for completion of needed well-child visits.

The interventions HPSM implemented may have contributed to the rates for the following measures moving from below the minimum performance levels in measurement year 2021 to above the minimum performance levels in measurement year 2022:

- *Cervical Cancer Screening*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for HPSM

Based on the overall assessment of HPSM's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of HPSM's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for HPSM show that the MCMC plan was fully compliant with seven of the 14 CFR standards.
- The HSAG auditor determined that HPSM followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- HPSM performed above the high performance levels for the following measures in measurement year 2022:
  - *Childhood Immunization Status—Combination 10*
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
  - *Immunizations for Adolescents—Combination 2*
  - *Prenatal and Postpartum Care—Postpartum Care*
- While HSAG assigned a *No Confidence* level to both of HPSM's 2020–22 PIPs, reflecting that the MCMC plan did not follow the approved PIP methodologies, HPSM noted lessons learned from conducting both PIPs that the MCMC plan may apply moving forward.

Opportunities for Improvement

- DHCS identified findings within seven of the CFR standards during the DHCS compliance review scoring process for HPSM.
- HPSM performed below the minimum performance level in measurement year 2022 for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visit* measure.

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure HPSM meets all CFR standard requirements moving forward.
- Assess the factors that contributed to HPSM performing below the minimum performance level in measurement year 2022 for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visit* measure and implement quality improvement strategies that target the identified factors.

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

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

Inland Empire Health Plan

Follow-Up on Prior Year Recommendation

Table C.17 provides the EQR recommendation HSAG made to IEHP in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendation. Please note that HSAG made minimal edits to Table C.17 to preserve the accuracy of IEHP's self-reported actions.

Table C.17—IEHP's Self-Reported Follow-Up on the External Quality Review Recommendation from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendation Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
1. For measures for which IEHP performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, IEHP should determine whether interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.	The following are quality improvement activities conducted between July 1, 2022, and June 30, 2023, to address measurement year 2021 performance measure rates that fell below the minimum performance levels: **Root Cause Analyses** IEHP conducted root cause analyses on the following measures with rates that fell below the minimum performance levels: ♦ *Cervical Cancer Screening* ♦ *Childhood Immunization Status—Combination 10* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* ♦ *Both Well-Child Visits in the First 30 Months of Life measures* **Quality Improvement Strategies** IEHP identified key insights, barriers, and opportunities for improvement for each

2021–22 External Quality Review Recommendation Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	measure. Below is a summary of actions taken by IEHP to improve performance on each measure using the insights from the root cause analyses to shape the approach. Key strategies included: ♦ Member incentives ♦ Provider incentives ♦ Member engagement activities ♦ Provider support activities ♦ Newborn enrollment activities ♦ Data capture improvements ♦ PCP connectivity improvements **Member Incentives** IEHP's member incentive programs continued in 2022 and included the following measures: ♦ *Cervical Cancer Screening* ♦ *Childhood Immunization Status—Combination 10* ♦ *Immunizations for Adolescents—Combination 2* New member incentive programs added during 2022 included well-care visits for members 16 to 21 years of age and well-child visits for members 15 months and 30 months of age, with a focus on children 7 to 12 months and 19 to 24 months of age. Members identified as needing a service were issued letters informing them of the incentive for completion of the needed service by the specified due date. IEHP also issued a request for proposal for a member incentive vendor solution to ensure that IEHP is leveraging the best resources/solutions to administer this program.

2021–22 External Quality Review Recommendation Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	Provider Incentives IEHP's Global Quality P4P and Obstetrician P4P programs continue to support various measures to improve provider performance. The Global Quality P4P program includes all measures that fell below the minimum performance levels. Additionally, the Global Quality P4P program includes newly added bonus payments for participating providers for services that fall under the *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* measures. The child and adolescent immunization bonus services allow providers the opportunity to obtain additional P4P incentive earnings and were introduced to improve data capture of all vaccines administered to the pediatric population. **Member Engagement** IEHP selected the *Cervical Cancer Screening* measure as a focus for the DHCS PDSA project. The project consisted of implementing phone outreach from the provider to members to encourage scheduling and completion of the screening. Additionally, the project included a text message campaign that shared education on cervical cancer during Cervical Cancer Awareness Month and provided information for members to schedule their appointments with their providers. Currently the provider is conducting outreach to members and offering a gift card incentive at the time of appointment. **Member Engagement** *Prenatal and Postpartum Care—Timeliness of Prenatal Care*: Conducted a PDSA project which focused on improving health outcomes for pregnant members and their children

2021–22 External Quality Review Recommendation Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	through the promotion of prenatal care visits early in their pregnancies. This involved identifying members who were newly enrolled with a pregnancy diagnosis and having our Maternal Mental Health Team outreach to at least 50 percent of the identified members via phone. IEHP outreached to a total of 196 members (96 percent), which exceeded the goal of 50 percent. Currently, IEHP is continuing to focus on identifying members at the earliest point in their pregnancies and looking for additional ways to provide help as early as possible. IEHP is currently conducting several projects with objectives focusing on improving childhood and immunizations measures. These projects include: ♦ **Member Engagement**—Member Health Scorecard: Share a health scorecard with members informing them of needed preventive health services, prioritizing the child and adolescent populations. ♦ **Provider Support Activities**—Quality Engagement Specialist: Provide office support to PCP offices through a new quality engagement specialist. The quality engagement specialist has assisted PCP offices with outreach related to the *Child and Adolescent Well-Care Visits—Total* and both *Well-Child Visits in the First 30 Months of Life* measures. ♦ **Provider Support Activities**—Actionable Provider Reports: Implement enhancements to provider-facing actionable reports available through the IEHP provider portal. ♦ **Newborn Enrollment Activities**—Post Delivery Coordination of Care: Partner with

2021–22 External Quality Review Recommendation Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	network hospitals to support coordination of care post-delivery, newborn enrollment, and scheduling well-baby visits. ♦ **Data Capture Improvements**—IEHP identified that data completeness may be impacted when services are provided for infants prior to the infants receiving their unique IEHP identification number. After implementing improvements in data completeness to connect the mom and baby records, IEHP saw an overall increase from 9.6 percent to 52.01 percent of members who had their mom records linked to the babies. This helped improve data capture for services rendered to babies when they are covered under their moms' eligibility. ♦ **Data Capture Improvements**—Newborn Hepatitis B Medical Record Review: Partner with network hospitals to collect EHRs for Hepatitis B administration after delivery. This work helped to improve the data capture of the Hepatitis B vaccine administered at birth that was not always captured through other administrative data sources.

Assessment of IEHP's Self-Reported Actions

HSAG reviewed IEHP's self-reported actions in Table C.17 and determined that IEHP adequately addressed the 2021–22 EQR recommendation. Based on results from a root cause analysis, IEHP implementing member- and provider-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2021, including:

- Offered incentives to members for completing cervical cancer screenings and needed immunizations.
- Offered provider incentives to improve performance on all measures with rates below the minimum performance levels in measurement year 2021.

- Conducted outreach to members due for their cervical cancer screenings to encourage them to schedule and complete their screenings.
- Conducted outreach to newly enrolled members with a pregnancy diagnosis to support them receiving timely prenatal care.
- Engaged with members and providers about children's preventive health services to improve access and completion of needed services.

The interventions IEHP implemented may have contributed to the rates for the following measures moving from below the minimum performance levels in measurement year 2021 to above the minimum performance levels in measurement year 2022:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for IEHP

Based on the overall assessment of IEHP's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of IEHP's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for IEHP show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that IEHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- IEHP performed above the high performance level in measurement year 2022 for the *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* measure.
- HSAG assigned a *High Confidence* level to IEHP's 2020–22 *Controlling High Blood Pressure Among African-American Members* Health Equity PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. IEHP's targeted medication review and member outreach

PIP interventions resulted in an increase in members who filled a 90-day prescription for their antihypertensive medications.

- HSAG assigned a *Moderate Confidence* level to IEHP's 2020–22 *Adolescent Well-Care Visits (Ages 18 to 21)* PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, and documented data to clearly link improvement to at least one tested intervention. IEHP's member outreach PIP interventions contributed to some eligible members being seen for their recommended well-care visits.

Opportunities for Improvement

- DHCS identified findings within three of the CFR standards during the DHCS compliance review scoring process for IEHP.
- IEHP performed below the minimum performance levels in measurement year 2022 for the following six of 15 measure rates that HSAG compared to benchmarks (40 percent):
  - *Cervical Cancer Screening*
  - *Child and Adolescent Well-Care Visits—Total*
  - *Childhood Immunization Status—Combination 10*
  - *Immunizations for Adolescents—Combination 2*
  - *Lead Screening in Children*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure IEHP meets all CFR standard requirements moving forward.
- For measures for which IEHP performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, IEHP should determine whether the member- and provider-focused interventions described in Table C.17 to improve cervical cancer screening, child and adolescent immunization, and well-child visit rates need to be revised or abandoned based on intervention evaluation results.

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

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

Kaiser NorCal

Follow-Up on Prior Year Recommendations

Table C.18 provides EQR recommendations HSAG made to Kaiser NorCal in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.18 to preserve the accuracy of Kaiser NorCal's self-reported actions.

Table C.18—Kaiser NorCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Address the findings from the 2021 A&I Medical Audit of Kaiser NorCal by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Member's Rights category.	Kaiser Permanente submitted responses to all corrective action findings to the DHCS Managed Care Quality and Monitoring Division, and the CAP was officially closed on November 2, 2022. With regard to the repeat finding in the Member's Rights category, Kaiser Permanente conducted additional training on regulatory resolution time frames, and instituted additional oversight of grievance timeliness.
2. For the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure, assess the factors, which may include COVID-19, that resulted in Kaiser NorCal performing below the minimum performance level for this measure in measurement year 2021 and implement quality improvement strategies that target the identified factors.	A significant decline in performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure in measurement year 2021 is attributed to the impact of COVID-19-related factors, including parents' willingness to bring their child in for an office visit. Beginning November 21, 2022, Kaiser NorCal implemented two PDSA cycles focused on improving performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure. Both PDSA cycles

2021–22 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	were focused on conducting outreach to families with children who had not scheduled their well-child visits. The first PDSA was focused on children ages 17 to 20 months and included outreach calls to schedule appointments and remind families of upcoming visits. The second PDSA cycle was focused on children ages 21 to 30 months who did not have visit 2 scheduled. Both goals were successfully achieved, and the rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure is once again well above the minimum performance level.

Assessment of Kaiser NorCal's Self-Reported Actions

HSAG reviewed Kaiser NorCal's self-reported actions in Table C.18 and determined that Kaiser NorCal adequately addressed the 2021–22 EQR recommendations. Kaiser NorCal indicated that the MCMC plan submitted responses to DHCS regarding all findings from the 2021 A&I Medical Audit and that DHCS closed the CAP on November 2, 2022.

Kaiser NorCal indicated that COVID-19 contributed to the MCMC plan performing below the minimum performance level for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure in measurement year 2021. To improve performance, Kaiser NorCal conducted outreach to families with children who had not scheduled their well-child visits and indicated that the intervention was successful. The MCMC plan's outreach efforts may have contributed to the rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure moving from below the minimum performance level in measurement year 2021 to above the minimum performance level in measurement year 2022.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Kaiser NorCal

Based on the overall assessment of Kaiser NorCal's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of Kaiser NorCal's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for Kaiser NorCal show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that Kaiser NorCal followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- Kaiser NorCal performed above the high performance levels for the following measures in measurement year 2022:
  - *Breast Cancer Screening—Total*
  - *Cervical Cancer Screening*
  - *Controlling High Blood Pressure—Total*
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
  - *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - *Immunizations for Adolescents—Combination 2*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- HSAG assigned a *High Confidence* level to both of Kaiser NorCal's 2020–22 PIPs, reflecting that the MCMC plan followed the approved PIP methodologies, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions.
  - Kaiser NorCal's *Childhood Immunizations* PIP member outreach interventions contributed to an increase in the number of eligible members completing vaccination services while attending their well-care visits.

- Kaiser NorCal's *Hypertension Control Among African-American Members Living in South Sacramento* Health Equity PIP member-focused interventions contributed to improvement in the percentage of members in the target group with controlled hypertension.

Opportunities for Improvement

- DHCS identified findings within six of the CFR standards during the DHCS compliance review scoring process for Kaiser NorCal.
- Kaiser NorCal performed below the minimum performance levels in measurement year 2022 for the following two of 15 measure rates that HSAG compared to benchmarks (13 percent):
  - *Child and Adolescent Well-Care Visits—Total*
  - *Lead Screening in Children*

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Kaiser NorCal meets all CFR standard requirements moving forward.
- Assess the factors that contributed to Kaiser NorCal performing below the minimum performance levels in measurement year 2022 for the *Child and Adolescent Well-Care Visits—Total* and *Lead Screening in Children* measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Kaiser NorCal should determine whether the successful member outreach interventions described in Table C.18 could be adapted to address the factors contributing to the MCMC plan performing below the minimum performance levels for these measures.

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

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

Kaiser SoCal

Follow-Up on Prior Year Recommendations

Table C.19 provides EQR recommendations HSAG made to Kaiser SoCal in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.19 to preserve the accuracy of Kaiser SoCal's self-reported actions.

Table C.19—Kaiser SoCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Address the findings from the 2021 A&I Medical Audit of Kaiser SoCal by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Quality Management category.	Kaiser Permanente submitted responses to all corrective action findings to the DHCS Managed Care Quality and Monitoring Division, and the CAP was officially closed on November 2, 2022. With regard to the repeat finding in the Quality Management category, Kaiser Permanente updated the Kaiser Permanente San Diego Medi-Cal and State Sponsored Programs Committee charter to include the qualifications of staff responsible for quality improvement studies and activities, including education, experience, and training. The updated charter was approved through Kaiser Permanente's quality committee structure.
2. For the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure, assess the factors, which may include COVID-19, that resulted in Kaiser SoCal performing below the minimum performance level for this measure in measurement year 2021 and implement	A significant decline in performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure in measurement year 2021 is attributed to the impact of COVID-19-related factors, including parents' willingness to bring their child in for an office visit as well as Kaiser

2021–22 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
quality improvement strategies that target the identified factors.	Permanente San Diego Ambulatory Pediatric Department staffing challenges. Kaiser SoCal engaged with Kaiser Permanente San Diego Ambulatory Pediatric Department stakeholders to proactively address Kaiser SoCal's performance being below the minimum performance level for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure in measurement year 2021. Kaiser SoCal initiated the following activities and interventions: ♦ The health care team used the existing Kaiser Permanente Health Connect EHR proactive office encounter workflow, care gap alerts, and panel management tools to outreach to parents to schedule 15- to 30-month well-child visits. ♦ Licensed vocational nurse office staff members conducted a focused telephonic outreach campaign to parents from May through July 2022 to schedule 15- to- 30-month well-child visit appointments for a July 16, 2022, Saturday clinic day event or a regular weekday clinic date based on parent preference. ♦ A required 2022 DHCS *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* PDSA cycle project was implemented on November 14, 2022, that will continue to December 1, 2023. During PDSA cycle 1, licensed vocational nurse office staff members used a newly developed weekly outreach patient list to conduct telephonic outreach to parents of children assigned to four

2021–22 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	pediatric clinics to schedule a first or second 15- to 30-month well-child visit. The intervention led to improvement and was adopted. For PDSA cycle 2, telephonic outreach was expanded to all 12 pediatric clinic locations. The 4.83 percentage point increase in the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure rate from December 2022 to April 2023 is attributed to the telephonic outreach conducted during the two PDSA cycles. The measurement year 2022 rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure was above the minimum performance level. Performance continues to improve in measurement year 2023.

Assessment of Kaiser SoCal's Self-Reported Actions

HSAG reviewed Kaiser SoCal's self-reported actions in Table C.19 and determined that Kaiser SoCal adequately addressed the 2021–22 EQR recommendations. Kaiser SoCal indicated that the MCMC plan submitted responses to DHCS regarding all findings from the 2021 A&I Medical Audit and that DHCS closed the CAP on November 2, 2022.

Kaiser SoCal indicated that COVID-19 contributed to the MCMC plan performing below the minimum performance level for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure in measurement year 2021. The MCMC plan attributed the rate for this measure improving to above the minimum performance level in measurement year 2022 to the targeted telephonic outreach clinic staff conducted at multiple pediatric clinic locations.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Kaiser SoCal

Based on the overall assessment of Kaiser SoCal's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of Kaiser SoCal's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for Kaiser SoCal show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that Kaiser SoCal followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- Kaiser SoCal performed above the high performance levels for the following measures in measurement year 2022:
  - *Breast Cancer Screening—Total*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status—Combination 10*
  - *Controlling High Blood Pressure—Total*
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
  - *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
  - *Immunizations for Adolescents—Combination 2*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- HSAG assigned a *High Confidence* level to both of Kaiser SoCal's 2020–22 PIPs, reflecting that the MCMC plan followed the approved PIP methodologies, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. Kaiser SoCal tested a reminder postcard intervention for both PIPs, which contributed to an increase in the percentage of eligible members who were seen for at least one well-care visit.

Opportunities for Improvement

- DHCS identified findings within six of the CFR standards during the DHCS compliance review scoring process for Kaiser SoCal.
- Kaiser SoCal performed below the minimum performance levels in measurement year 2022 for the following two of 15 measure rates that HSAG compared to benchmarks (13 percent):
  - *Child and Adolescent Well-Care Visits—Total*
  - *Lead Screening in Children*

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Kaiser SoCal meets all CFR standard requirements moving forward.
- Assess the factors that contributed to Kaiser SoCal performing below the minimum performance levels in measurement year 2022 for the *Child and Adolescent Well-Care Visits—Total* and *Lead Screening in Children* measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Kaiser SoCal should determine whether the successful member- and provider-focused interventions described in Table C.19 could be adapted to address the factors contributing to the MCMC plan performing below the minimum performance levels for these measures.

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

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

Kern Family Health Care

Follow-Up on Prior Year Recommendations

Table C.20 provides EQR recommendations HSAG made to KHS in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.20 to preserve the accuracy of KHS' self-reported actions.

Table C.20—KHS' Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Address the findings from the 2021 A&I Medical Audit of KHS by implementing the actions recommended by A&I.	KHS submitted a CAP related to the 2021 A&I Medical Audit on March 8, 2022. We had 14 findings across six categories and implemented 76 improvements to address and rectify the findings. Corrective actions included but were not limited to policy updates, desktop procedures and job aid improvements, refresher training, internal monitoring and auditing updates, and provider education. KHS worked with DHCS to provide the appropriate supporting documentation to resolve the deficiencies, and DHCS closed the CAP as of March 2, 2023.
2. For measures for which KHS performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, KHS should determine whether initiatives the plan previously implemented need to be revised or	Measures that did not meet the minimum performance levels for measurement year 2021: ♦ *Cervical Cancer Screening* ♦ *Child and Adolescent Well-Care Visits—Total* ♦ *Childhood Immunization Status—Combination 10* ♦ *Chlamydia Screening in Women—Total* ♦ *Immunizations for Adolescents—Combination 2*

2021–22 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
abandoned based on intervention evaluation results.	♦ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* ♦ Both *Well-Child Visits in the First 30 Months of Life* measures KHS conducted a PIP to address a health care disparity related to the *Child and Adolescent Well-Care Visits—Total* measure and increase the well-care visit compliance rate. ♦ In accordance with DHCS requirements, the PIP was in place for two years (2020–22). The PIP focused on improving the health and well-being of low-income children, ages 8 to 10 years, by aligning the well-child visit with industry standards of care and evidence-based practices. With COVID-19 being a factor contributing to limited in-person interventions, KHS implemented our member engagement and rewards program (MERP). MERP included special outreach campaigns and incentive rewards for the members. For this PIP, we included outreaching to members through mailers and robocalls as well as incentivizing the members with the member rewards. MERP leverages two primary approaches to support members toward self-management. The first approach provides an array of options for contacting, educating, and engaging

2021–22 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	members such as IVR calls, text messaging, mailed letters and materials, and live phone calls. The second approach provides a reward to members to encourage them to follow through with specific preventive health or condition management services and activities. For 2022, members were incentivized for completing services related to the following measures: ♦ *Child and Adolescent Well-Care Visits—Total* ♦ Both *Prenatal and Postpartum Care* measures ♦ Both *Well-Child Visits in the First 30 Months of Life* measures Members also were offered incentives for completing their initial health assessment (IHA). MERP was expanded to include four new measures: ♦ *Breast Cancer Screening—Total* ♦ *Cervical cancer Screening* ♦ *Chlamydia Screening in Women—Total* ♦ *Lead Screening in Children* In November 2022, the MERP rewards were increased to continue to incentivize members to close their gaps in care, and text messaging was launched to remind members of their outstanding gaps in care. SWOT Project: ♦ The KHS SWOT Team received DHCS' feedback for revised SWOT initial strategies and action items on December 15, 2021. The next submission was on February 11, 2022. We have partnered with

2021–22 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	KHS' Health Education Team to provide Bakersfield City School District with point-of-care gift cards for closing gaps in care. As a result of KHS' measurement year 2020 MCAS scores, the KHS Quality Improvement Team is performing two PDSA projects required by DHCS. ♦ The first PDSA project is focused on the *Breast Cancer Screening—Total* measure in the Women's Health domain. The specific intervention is to measure the volume of mammograms completed via the mobile mammogram clinic, which was conducted on October 29, 2021, in the town of Taft. Currently, we are in the planning phase for the next mobile mammography clinic for cycle 2 of this PDSA project. ♦ The second PDSA project is focused on the *Well-Child Visits in the First 30 Months of Life* measure, with a focus on ages 0 to 15 months. We are partnering with Clinica Sierra Vista to conduct a two-pronged approach using robocalls and direct telephonic outreach. The goal is to increase the MCAS compliance rate by 5 percentage points. The Organizational Quality Incentives Project was a short-term project intended to improve KHS' MCAS compliance for measurement year 2022. The project included the following strategies: ♦ Existing Supplemental Data—Incorporated existing supplemental data into annual MCAS data processing (e.g., Kaiser, DHCS).

2021–22 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	♦ PCP Support for Prenatal Care—Provided education to PCPs for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure compliance. ♦ Quarterly Provider Visits—Consolidated provider MCAS performance reports into one to use for review during quarterly provider visits. ♦ Member Services Outreach—Piloted focusing on use of Member Services to do direct member outreach to advise of MCAS gaps in care and assist with setting up an appointment. Focus was on the lowest-volume providers, working up to higher-volume providers. ♦ Mobile Preventive Health Services Pilot—This pilot was with Adventist Health and included providing adolescent immunizations and chlamydia testing for women. Mobile services were being offered in the McFarland and Arvin communities. ♦ Used urgent care centers to deliver select preventive health services. ♦ Standing Orders—KHS plans to provide standing orders for mammograms, chlamydia testing, blood lead testing, and HbA1c testing. This strategy includes outreach, directing members to get their screening with a specialist who has a standing order from KHS. Note that the scope of this initiative is being reviewed and evaluated by KHS' Compliance Team, which generates orders currently planned for Universal Health Care, with lab support from Kern Radiology. KHS is currently uncertain of other labs that would be involved and who will own responsibility for follow-up with members regarding test results.

2021–22 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	End of the Year MCAS Focus ♦ At the end of the year, KHS focused on the closure of gaps in care. We offered point-of-service gift cards to members who were able to close gaps in care for MCAS measures.

Assessment of KHS' Self-Reported Actions

HSAG reviewed KHS' self-reported actions in Table C.20 and determined that KHS adequately addressed the 2021–22 EQR recommendations. KHS indicated that the MCMC plan submitted a CAP to DHCS for the findings from the 2021 A&I Medical Audit. KHS implemented corrective actions, including:

- Updated policies.
- Improved desktop procedures and job aids.
- Conducted refresher trainings.
- Updated internal monitoring and auditing processes.
- Conducted provider education.

KHS indicated that based on the information the MCMC plan submitted, DHCS closed the CAP on March 2, 2023.

For performance measures for which KHS performed below the minimum performance levels in measurement year 2021, the MCMC plan implemented member- and provider-focused interventions via a PIP, PDSA cycles, and as part of a SWOT project, including:

- Offered member incentives.
- Conducted member outreach.
- Offered mobile mammography services.

KHS also implemented a short-term project to improve performance on MCAS measures. The project included strategies aimed at supporting providers and members so that members have access to and receive needed services.

The interventions and strategies KHS implemented may have contributed to the rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure moving from below the

minimum performance level in measurement year 2021 to above the minimum performance level in measurement year 2022.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for KHS

Based on the overall assessment of KHS' delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of KHS' activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for KHS show that the MCMC plan was fully compliant with six of the 14 CFR standards.
- The HSAG auditor determined that KHS followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- HSAG assigned a *High Confidence* level to KHS' 2020–22 *Asthma Medication Ratio* PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. KHS tested one provider-focused and two member-focused interventions that contributed to beneficiaries with persistent asthma increasing their use of controller medications rather than rescue medications.
- HSAG assigned a *Moderate Confidence* level to KHS' 2020–22 *Well-Child Visits Among Members Living in Central Bakersfield* Health Equity PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, and documented data to clearly link improvement to at least one tested intervention. KHS' multi-mode member outreach PIP intervention contributed to an increase in the percentage of eligible members who completed their well-care visits at the clinic partner.

Opportunities for Improvement

- DHCS identified findings within eight of the CFR standards during the DHCS compliance review scoring process for KHS.
- KHS performed below the minimum performance levels in measurement year 2022 for the following 10 of 15 measure rates that HSAG compared to benchmarks (67 percent):

- *Cervical Cancer Screening*
- *Child and Adolescent Well-Care Visits—Total*
- *Childhood Immunization Status—Combination 10*
- *Chlamydia Screening in Women—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
- *Immunizations for Adolescents—Combination 2*
- *Lead Screening in Children*
- Both *Well-Child Visits in the First 30 Months of Life* measures

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure KHS meets all CFR standard requirements moving forward.
- For measures for which KHS performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, KHS should determine whether the member-, provider-, and system-focused interventions described in Table C.20 for those measures that remained below the minimum performance levels in measurement year 2022 need to be revised or abandoned based on intervention evaluation results.

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

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

L.A. Care Health Plan

Follow-Up on Prior Year Recommendations

Table C.21 provides EQR recommendations HSAG made to L.A. Care in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.21 to preserve the accuracy of L.A. Care's self-reported actions.

Table C.21—L.A. Care's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Address the findings from the 2021 A&I Medical Audit of L.A. Care by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Utilization Management and Access and Availability of Care categories.	L.A. Care submitted a CAP addressing each of the findings identified in the 2021 A&I Medical Audit, in alignment with the A&I recommendations. The MCMC plan has tracked implementation and responded to follow-up questions and documentation requests from DHCS. Regarding the repeat finding in the Utilization Management category (L.A. Care did not ensure a delegate complied with subcontractor ownership and control disclosure requirements), L.A. Care provided training to its provider network management staff, sent written communications to and met with its delegates to educate them on ownership and control disclosure requirements, and implemented an annual ownership and control attestation process. Regarding the repeat finding in the Access and Availability of Care category (L.A. Care did not ensure that its NEMT and NMT subcontractors were enrolled in the Medi-Cal program), L.A. Care accelerated any pending subcontracted transportation provider Medi-Cal applications, removed subcontractors who were not enrolled in Medi-Cal, and implemented an escalation processes to issue notices of noncompliance

2021–22 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	and require corrective action if services were performed by unenrolled subcontractors.
2. Assess whether the strategies the plan previously implemented to improve child immunization rates need to be revised or abandoned based on L.A. Care's performance for the *Childhood Immunization Status—Combination 10* measure remaining below the minimum performance level in measurement year 2021.	With the success of the *Childhood Immunization Status—Combination 10* PIP and 2021 member touchpoints, L.A. Care plans to enhance and make additions to the current interventions of mailers, automated calls, and social media. Enhancements include making the automated calls and social media campaign biannual versus annual. These additional touchpoints are based on member feedback. L.A. Care will also implement a flu intervention to increase flu vaccine rates among members 0 to 2 years old. Lastly, L.A. Care is adding provider touchpoints. These include webinars that highlight the missing vaccine reports and newsletter announcements.
3. For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in L.A. Care performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors.	Factors that resulted in not meeting the minimum performance level for both *Well-Child Visits in the First 30 Months of Life* measures were: ♦ COVID-19 causing competing clinical priorities for providers and member hesitancy to attend appointments. ♦ High turnover of clinical staff, impeding access to care. ♦ Lack of data to providers. To remedy these factors, L.A. Care implemented three main strategies: 1. Hired nursing staff to provide additional support to clinics and better access to care. 2. Launched a new *Well-Child Visits in the First 30 Months of Life* report. By providing additional details regarding the 0- to 30-month visits (e.g., number of visits),

2021–22 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	providers can better catch up on and anticipate visits. 3. Added additional member touchpoints (calls and social media campaigns) to encourage parents/guardians to return to the provider office.

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

HSAG reviewed L.A. Care's self-reported actions in Table C.21 and determined that L.A. Care adequately addressed the 2021–22 EQR recommendations. L.A. Care indicated that the MCMC plan submitted a CAP to DHCS, addressing each of the findings from the 2021 A&I Medical Audit. L.A. Care stated that it has tracked implementation of CAP action items and responded to follow-up questions and documentation requests from DHCS.

To address the MCMC plan performing below the minimum performance level in measurement year 2021 for the *Childhood Immunization Status—Combination 10* measure, L.A. Care indicated building on successful interventions tested via the *Childhood Immunization Status—Combination 10* PIP, including increasing member and provider touchpoints. The strategies L.A. Care implemented may have contributed to the rate for the *Childhood Immunization Status—Combination 10* measure improving from below the minimum performance level in measurement year 2021 to above the minimum performance level in measurement year 2022.

L.A. Care indicated that the ongoing effects of COVID-19, clinical staff turnover, and lack of data to providers contributed to the MCMC plan performing below the minimum performance levels for both *Well-Child Visits in the First 30 Months of Life* measures in measurement year 2021. L.A. Care reported hiring nursing staff, launching a new provider well-child visits report, and adding additional member touchpoints to improve performance on these measures.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for L.A. Care

Based on the overall assessment of L.A. Care's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of L.A. Care's activities and services affect the quality, accessibility, and timeliness of care delivered to its members.

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

Strengths

- DHCS' compliance review scores for L.A. Care show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that L.A. Care followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- HSAG assigned a *High Confidence* level to L.A. Care's 2020–22 *Childhood Immunizations* PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions. L.A. Care's member outreach PIP intervention with the clinic partner contributed to an increase in the percentage of members at the clinic partner who received their needed vaccine doses.
- HSAG assigned a *Moderate Confidence* level to L.A. Care's 2020–22 *Diabetes Among African-American Members* Health Equity PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, and documented data to clearly link improvement to at least one tested intervention. L.A. Care's member outreach PIP interventions contributed to improvement in HbA1c levels for eligible African-American members assigned to the community center partner.

Opportunities for Improvement

- DHCS identified findings within six of the CFR standards during the DHCS compliance review scoring process for L.A. Care.
- L.A. Care performed below the minimum performance levels in measurement year 2022 for the following six of 15 measure rates that HSAG compared to benchmarks (40 percent):
  - *Cervical Cancer Screening*
  - *Child and Adolescent Well-Care Visits—Total*
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Lead Screening in Children*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure L.A. Care meets all CFR standard requirements moving forward.
- For measures for which L.A. Care performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on

these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, L.A. Care should determine whether the member- and provider-focused interventions described in Table C.21 to improve well-child visit rates need to be revised or abandoned based on intervention evaluation results.

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

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

Molina Healthcare of California

Follow-Up on Prior Year Recommendation

Table C.22 provides the EQR recommendation HSAG made to Molina in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendation. Please note that HSAG made minimal edits to Table C.22 to preserve the accuracy of Molina's self-reported actions.

Table C.22—Molina's Self-Reported Follow-Up on the External Quality Review Recommendation from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
1. For measures for which Molina performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Molina should determine whether interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.	Factors related to the ongoing COVID-19 pandemic, including the emergence of new and more transmittable variants, continued to impact Molina's measurement year 2021 performance. Quality improvement strategies targeting these factors were implemented that addressed member and provider barriers to accessing preventive and other health care services. Molina also conducted MCMC plan- and provider-focused, county-specific, Ishikawa diagram causal and barrier analyses for all measurement 2021 rates that fell below the minimum performance levels in Imperial, Sacramento, and Riverside/San Bernardino counties. Potential causes were grouped under the categories of Collaboration, Accountability, Data, Monitoring and Evaluation, and Communication. Molina evaluated whether interventions the MCMC plan previously implemented needed to be revised or abandoned based on intervention evaluation results. Value-added

2021–22 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	revisions included P4P and member incentives. Following are the 2021–22 interventions Molina continued implementing, including changes Molina made to improvement strategies: ♦ *Breast Cancer Screening—Total* ■ Monitored the number of mammograms completed at RadNet sites to confirm improved access to breast cancer screening. ■ Added a P4P program for RadNet. ■ Monitored breast cancer screening rates for members of IPAs having a mammogram standing order process with RadNet. ■ Enhanced provider P4P and value-based payment programs for PCPs. ■ Enhanced member incentives to be more user-friendly, including offering electronic fulfillment in real time if preferred by the member. ♦ *Cervical Cancer Screening* ■ Molina's Practice Transformation Team distributed cervical cancer screening gaps-in-care reports to all high-volume network PCPs across all counties. ■ Practice transformation specialists educated high-volume network PCPs about the following best practices and monitored implementation: ○ Use of gaps-in-care reports for member engagement. ○ Roster reconciliation to make sure cervical cancer screening

2021–22 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	encounters were accurately submitted. ■ Enhanced provider P4P and value-based payment programs for PCPs and OB/GYNs. ■ Enhanced member incentives to be more user-friendly, including offering electronic fulfillment in real time if preferred by the member. ♦ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* ■ Molina's Practice Transformation Team educated targeted PCPs and OB/GYNs to use and properly submit Pregnancy Notification Forms (PNFs). ■ Monitored PNF submission rates to confirm improved compliance with the use of the form. ■ Enhanced workflows to connect members to various community resources such as Black Infant Health, Mamas y Bebes, and doula referrals. ■ Enhanced provider P4P and value-based payment programs for PCPs and OB/GYNs. ■ Enhanced member incentives to be more user-friendly, including offering electronic fulfillment in real time if preferred by the member. ■ Partnered with a vendor, Lucina, to identify pregnancies much earlier than relying on claims and encounters. This intervention began in February 2023. ♦ *Prenatal and Postpartum Care—Postpartum Care* ■ Used the PNF to identify pregnant members and promote postpartum visits prior to delivery.

2021–22 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	■ Molina's outreach team assisted members with scheduling postpartum visits. ■ Enhanced workflows to connect members to various community resources such as Black Infant Health, Mamas y Bebes, and doula referrals. ■ Enhanced provider P4P and value-based payment programs for PCPs and OB/GYNs. ■ Enhanced member incentives to be more user-friendly, including offering electronic fulfillment in real time if preferred by the member. ■ Increased Molina Care Connections in-home and telehealth postpartum visits. ♦ *Childhood Immunizations—Combination 10* ■ Continued the following interventions through December 31, 2022, for the 2020–22 Child and Adolescent Health PIP in Sacramento County: ○ Provided a monthly list to the clinic of eligible children who had their California Immunization Registry 2 status set to "Undisclosed" so that the clinic could correct the status to "Disclosed" (i.e., open for sharing, coded "O"). ○ Monitored the California Immunization Registry 2 monthly for status updates. ○ Accessed the California Immunization Registry 2 monthly to download members' registry data as they became disclosed for sharing. ○ IVR reminder calls to parents/guardians of members due for vaccinations related to the

2021–22 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	Childhood Immunizations—Combination 10 measure. ○ Expanded the interventions to all counties in 2023 to members in need of completing their vaccinations related to the *Childhood Immunizations—Combination 10* measure before their second birthday. ○ Enhanced provider P4P and value-based payment programs for PCPs. ○ Enhanced member incentives to be more user-friendly, including offering electronic fulfillment in real time if preferred by the member. ♦ *Immunizations for Adolescents—Combination 2* ■ Outreached to members to schedule appointments using reports of members noncompliant for immunizations included in the *Immunizations for Adolescents—Combination 2* measure who were assigned to Borrego Clinics in Riverside/San Bernardino counties and who were aging out of the measure in 30, 60, and 90 days. ■ Scheduled immunization appointments directly into clinic EHRs. ■ Enhanced provider P4P and value-based payment programs for PCPs. ♦ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)* ■ Continued the following interventions through December 31, 2022, for the 2020–22 Health Equity PIP in Sacramento County:

2021–22 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	○ Completed home HbA1c testing for eligible Black/African-American members. ○ Expanded completing home HbA1c testing for eligible members to all counties in 2023. ○ Enhanced provider P4P and value-based payment programs for PCPs. ♦ *Controlling High Blood Pressure—Total* ■ Gave funding to clinics to provide home blood pressure monitoring kits to members in Sacramento County who did not have controlled blood pressure. This allowed members to monitor and report at-home blood pressure readings to their PCPs during telehealth and in-person visits. ■ Enhanced provider P4P and value-based payment programs for PCPs. Following are new interventions Molina implemented in 2022–23, by reporting unit. **Imperial County**—Provider collaboration and communication related to all MCAS HEDIS measures. Molina identified the following barriers: ♦ Provider lack of understanding of changing HEDIS measures and reporting requirements. ♦ Molina's inadequate communication to providers of HEDIS changes. ♦ Lack of updated provider educational materials to support HEDIS changes and reporting requirements. ♦ Lack of engagement of key provider staff.

2021–22 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	Molina implemented the following strategies to address these barriers in Imperial County: ♦ Molina's quality leadership collaborated with the Imperial County Physician Advisory Network to identify and adopt techniques for more effective communication of HEDIS measure change processes. ♦ Molina's health education staff members and medical directors collaborated to update provider HEDIS "Change Package" educational materials to meet the needs of providers and ensure that materials were user-friendly, actionable, and concise. ■ Molina's MCAS change communication educational materials presented the measures that were newly held to the 50th percentile, any coding or technical specification changes, and tips for enhancing workflows to meet the measure requirements. ♦ Collaborated with providers to ensure that their key clinic stakeholders remain engaged in implementing needed changes. **Imperial and Sacramento Counties**—Breast cancer screening, cervical cancer screening, and well-child visits. Molina identified the following barriers: ♦ Lack of accurate member outreach data. ♦ Inadequate provider incentive programs to improve member engagement for needed preventive services. ♦ Lack of strategic member engagement methods beyond mailings. ♦ Lack of accurate member outreach data (email and telephone numbers).

2021–22 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	Molina implemented the following strategies to address these barriers in Imperial and Sacramento counties: ♦ Member Engagement Award Program ■ Sent participating providers a list of members historically noncompliant for breast cancer screenings, cervical cancer screenings, and well-child visits. ■ Offered providers incentives for each noncompliant member who completed a targeted screening/service. **Imperial, Sacramento, San Diego, and Riverside/San Bernardino Counties**—All MCAS HEDIS Measures. Molina identified the following barriers: ♦ Lack of accurate member outreach data. ♦ Lack of strategic member engagement methods beyond mailings. ♦ Lack of accurate member outreach data (email and telephone numbers). Molina implemented the following strategies to address these barriers in Imperial, Sacramento, San Diego, and Riverside/San Bernardino counties: ♦ Molina's consent preference management team collaborated with a contracted vendor to collect valid member contact information and preferred modalities, including email addresses. ■ Molina will share updated member information with PCPs to improve the success of their preventive care outreach campaigns.

2021–22 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	♦ Implemented member email reminders for completing IHAs. ■ Providers assess members' needed preventive services and immunizations during the IHA. **Sacramento County**—All MCAS HEDIS Measures. Molina identified the following barriers: ♦ Inaccuracy of encounter data submission. ♦ Lack of a Molina data reconciliation process. Molina implemented the following strategies to address these barriers in Sacramento County: ♦ Developed a data reconciliation process in which supplemental data submissions are validated against encounter submissions to identify data inaccuracies and determine the root cause of the data gap. ♦ Shared a validation scorecard with a pilot provider group to initiate solution planning and data submission monitoring. **Riverside/San Bernardino Counties**—*Prenatal and Postpartum Care—Timeliness of Prenatal Care*. Molina identified the following barrier: ♦ Inadequate early identification of pregnant members. Molina implemented the following strategies to address this barrier in Riverside/San Bernardino counties: ♦ Partnered with a contracted vendor, Lucina, a data aggregator that uses an algorithm which scrubs data for over 3,000 signals to

2021–22 External Quality Review Recommendation Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	find pregnant members within the first trimester. On average, this vendor identifies pregnancies 15 weeks faster compared to standard Molina logic that relies on claims/encounters and provider/member reported pregnancies. ♦ Molina's maternal health outreach team added the vendor-identified pregnancies into its outreach targets lists and tracked prenatal appointments scheduled and referrals to doulas and local programs such as Mamas Y Bebes and Black Infant Health.

Assessment of Molina's Self-Reported Actions

HSAG reviewed Molina's self-reported actions in Table C.22 and determined that Molina adequately addressed the 2021–22 EQR recommendation. Molina indicated that factors related to the ongoing COVID-19 pandemic contributed to the MCMC plan performing below the minimum performance levels for several measure rates in measurement year 2021. Molina reported that the MCMC plan conducted barrier analyses for all measures with rates below the minimum performance levels in measurement year 2021 and evaluated whether interventions Molina had previously implemented needed to be revised or abandoned. Molina provided detailed descriptions of interventions the MCMC plan implemented to improve performance on measures for which it performed below the minimum performance levels in measurement year 2021, including:

- Provider-focused interventions:
  - Expanded and enhanced P4P and value-based payment programs.
  - Distributed gaps-in-care reports to providers to improve their breast cancer screening, cervical cancer screening, and well-child visit rates.
  - Conducted provider trainings on best practices related to cervical cancer screenings.
  - Provided funding to clinics to provide home blood pressure monitoring kits to members in Sacramento County who did not have controlled blood pressure.
- Member-focused interventions:
  - Enhanced member incentives.
  - Conducted member outreach to assist members with scheduling needed appointments.

  - Implemented an email strategy to remind members to complete needed preventive services during their IHAs.
  - Enhanced MCMC plan workflows to help connect members with needed community resources.
  - As part of the 2020–22 Health Equity PIP, completed home HbA1c testing for eligible Black/African-American members in Sacramento County and in 2023, expanded home testing to all counties.
- Data enhancement interventions:
  - Monitored California Immunization Registry 2 data monthly.
  - Implemented process improvements to ensure encounter data accuracy.
  - Partnered with a vendor to identify pregnant members within the first trimester.

The interventions Molina implemented may have contributed to the rates for the following measures moving from below the minimum performance levels in measurement year 2021 to above the minimum performance levels in measurement year 2022:

- *Breast Cancer Screening—Total* for Imperial County
- *Child and Adolescent Well-Care Visits—Total* for Sacramento County
- *Childhood Immunization Status—Combination 10* for Imperial County
- *Controlling High Blood Pressure—Total* for Sacramento County
- *Immunizations for Adolescents—Combination 2* for Sacramento County
- Both *Prenatal and Postpartum Care* measures for Sacramento County
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* for San Diego County

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Molina

Based on the overall assessment of Molina's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of Molina's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for Molina show that the MCMC plan was fully compliant with all but one of the 14 CFR standards.

- The HSAG auditor determined that Molina followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- Molina performed above the high performance levels for the following measures in measurement year 2022:
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* for Imperial County
  - *Prenatal and Postpartum Care—Postpartum Care* for San Diego County
- Based on its performance measure results across all reporting units, Molina performed best in San Diego County, where the MCMC plan met or exceeded the minimum performance levels for 12 performance measure rates.
- HSAG assigned a *High Confidence* level to both of Molina's 2020–22 PIPs, reflecting that the MCMC plan followed the approved PIP methodologies, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions.
  - Molina's *Childhood Immunizations* PIP immunization registry data improvement and member outreach interventions contributed to an increase in the number of members who received their recommended vaccination doses.
  - Molina's *Diabetes Control Among African-American Members Residing in Sacramento County* Health Equity PIP intervention, which included the MCMC plan mailing home HbA1c testing kits to eligible African-American members with diabetes in Sacramento County, contributed to an increase in the number of these members completing their recommended HbA1c test.

Opportunities for Improvement

- DHCS identified findings within one of the CFR standards during the DHCS compliance review scoring process for Molina.
- Across all reporting units in measurement year 2022, Molina performed below the minimum performance levels for 33 of 60 measure rates that HSAG compared to benchmarks (55 percent).
- Performance measure results show that Molina has opportunities for improvement across all reporting units, with the greatest opportunities for improvement in Riverside/San Bernardino counties, where Molina performed below the minimum performance levels for 13 performance measure rates.

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Molina meets all CFR standard requirements moving forward.
- For measures for which Molina performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified

factors. As part of this assessment, Molina should determine whether the interventions described in Table C.22 need to be revised or abandoned based on intervention evaluation results.

- Based on measurement year 2022 performance measure results, Molina should prioritize implementing quality improvement strategies in Riverside/San Bernardino counties.

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

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

Partnership HealthPlan of California

Follow-Up on Prior Year Recommendation

Table C.23 provides the EQR recommendation HSAG made to Partnership in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendation. Please note that HSAG made minimal edits to Table C.23 to preserve the accuracy of Partnership's self-reported actions.

Table C.23—Partnership's Self-Reported Follow-Up on the External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendation Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
1. For measures for which Partnership performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Partnership should determine whether interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.	Partnership saw minor improvement in measurement year 2021 rates following the significant drop in measurement year 2020 due to the COVID-19 pandemic. When reviewing year-over-year data from measurement year 2019 to measurement year 2022, Partnership noted a gradual increase in MCAS measure rates; however, they have not yet returned to pre-COVID-19 levels. Upon further analysis, Partnership observed that when factoring the nine MCAS measures with rates that have remained constant from measurement year 2019 to measurement year 2020, rates have returned to pre-COVID-19 levels. Those nine measures include: ♦ *Breast Cancer Screening—Total* ♦ *Cervical Cancer Screening* ♦ *Childhood Immunization Status—Combination 10* ♦ *Chlamydia Screening in Women—Total* ♦ *Controlling High Blood Pressure—Total* ♦ *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9%)*

2021–22 External Quality Review Recommendation Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	♦ *Immunizations for Adolescents—Combination 2* ♦ Both *Prenatal and Postpartum Care* measures There are measures for which Partnership continues to perform below the minimum performance levels, as the MCMC plan did prior to the COVID-19 pandemic. While the effects of the pandemic are indeed diminishing, many provider practices continue to struggle with long-term effects like staffing shortages. According to a provider network survey, PCP vacancies across Partnership's 14 counties range from 15 percent to 38 percent, with an average of 24 percent. Shortages extending beyond PCPs also continue to prevail across the network. Imaging center access continues to prove challenging, affecting access to services like mammography. Partnership conducted secret shopper calls to imaging centers to assess access, with varying results. Some imaging centers are able to see patients within one week, while others have exhaustive waitlists. One rural imaging center along the State border only offers mammograms one day a week and recommends patients seek care in the neighboring state. This has prompted Partnership to expand efforts to offer mobile mammography services to address imaging center deserts. Partnership has continued to lead internal workgroups dedicated to Quality Measure Score Improvement given success in the prior year. In total, Partnership has the following five

2021–22 External Quality Review Recommendation Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	multi-functional workgroups dedicated to the various MCAS measure domains: ♦ Pediatrics ♦ Women's Health and Perinatal Health ♦ Medication Management ♦ Chronic Diseases ♦ Behavioral Health Each workgroup works with representatives across the organization to identify high-value interventions using data and presents recommendations to executives to ensure alignment with organizational objectives. Several examples of efforts resulting from the Quality Measure Score Improvement workgroups include: ♦ Partnership collaborated with local schools in Shasta County to offer on-site immunization events for adolescents. Stakeholders included school nurses, local pharmacies, and local providers. Given that students may have various insurance coverage, coordination was required to ensure that vaccines from the Vaccines for Children program were used for Medicaid beneficiaries only. One local pharmacy is currently enrolled in the Child Health and Disability Prevention Program pilot allowing pharmacies to administer the Vaccines for Children program stock, which eliminated the need for a provider staff member to administer those immunizations from the provider's supply. Partnership also paired these events with poster campaign projects wherein Partnership offered immunization education in class, and students created informational vaccine posters. Students

2021–22 External Quality Review Recommendation Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	voted on peer posters to determine winners who received an incentive. ♦ Partnership expanded its Healthy Kids Growing Together Program by adding 3- to 6-year-olds. Previously, the program engaged expecting members through their deliveries and into the early stages of infant care. As part of the program, Partnership staff conduct periodic telephonic outreach to educate members on important milestones in their pregnancies or their child's early development, stressing the importance of timely well visits and immunizations. Partnership also offers incentives at key milestones, including the annual 3- to 6-year well visits. ♦ Partnership's Population Health Team led multiple efforts aimed at engaging members to improve hypertension outcomes. The team has hosted or attended community hypertension events, as well as conducted telephonic outreach to targeted members. The Population Health Team educates members and offers resources such as healthy living tools as well as options for remote blood pressure monitoring. Upon conducting an analysis of hypertension outreach campaigns, 60 percent of members contacted scheduled an appointment with their PCP within 41 days of outreach. ♦ Partnership interviewed providers and public health departments across its 14 counties to determine barriers and opportunities for screening children for blood lead. Several observations were made: ■ Point-of-care testing is a best practice.

2021–22 External Quality Review Recommendation Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	▪ Many practices struggled to screen due to the supply recall. ▪ Not all public health departments have labs to support screening. ▪ Public health departments have challenges billing for blood lead testing. Partnership has opted to offer grants to a cohort of provider organizations to implement point-of-care testing to improve blood lead screening. ♦ In 2022, Partnership piloted mobile mammography events in partnership with an external vendor and 11 provider organizations. Based on the best practices learned during this pilot, Partnership launched a mobile mammography program in 2023, with the goal of sponsoring events hosted by providers located in imaging center deserts, in locations where local imaging centers continue to have significant access issues, and in counties with breast cancer screening rates below the NCQA 50th percentile benchmark. Partnership funds the mobile events and provides extensive technical assistance to providers who host events for their patient populations. Partnership has developed a two-pronged approach to work with its provider network to systematically improve quality measure rates planwide: ♦ Enhanced Provider Engagement: Partnership has identified providers earning less than 33 percent of their Quality Incentive Program points and has engaged in deliberate discussions with these providers to develop strategies to improve quality rates. This strategy requires

2021–22 External Quality Review Recommendation Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	ongoing collaboration with Partnership's performance improvement coaches throughout the measurement year, completion of an organizational self-assessment, as well as Partnership's leadership presenting their quality rates to the provider organization board or stakeholders. ♦ Modified Quality Incentive Program: During the COVID-19 pandemic, Partnership narrowed the number of measures in its incentive program to create a narrow focus as providers navigated the public health emergency. Partnership observed that rates for measures within the modified Quality Incentive Program performed much better than measures that were not incentivized. Partnership has elected to use a similar approach for a subset of the providers identified in the Enhanced Provider Engagement strategy noted above. The measures included are *Breast Cancer Screening—Total*, *Cervical Cancer Screening*, *Child and Adolescent Well-Care Visits—Total*, and both *Well-Child Visits in the First 30 Months of Life* measures.

Assessment of Partnership's Self-Reported Actions

HSAG reviewed Partnership's self-reported actions in Table C.23 and determined that Partnership adequately addressed the 2021–22 EQR recommendation. Partnership indicated that while the rates for some performance measures have returned to pre-COVID-19 levels, factors related to COVID-19 continue to affect the MCMC plan's performance on some measures. Factors include staffing shortages, which affect member access to needed services. In response to the challenges, Partnership continued convening internal workgroups dedicated to improving performance measure rates. Efforts resulting from these workgroups included:

- Partnering with local schools in Shasta County to offer on-site immunization events for adolescents.

- Expanding the MCMC plan's Healthy Kids Growing Together Program to include 3- to 6-year-olds.
- Conducting outreach to members with hypertension to help them schedule needed appointments and improve health outcomes.
- Offering grants to select provider organizations to implement point-of-care blood lead screening.
- Enhancing provider engagement efforts.
- Modifying the MCMC plan's provider incentive program.
- Expanding mobile mammography events.

The strategies Partnership implemented may have contributed to the rates for the following measures moving from below the minimum performance levels in measurement year 2021 to above the minimum performance levels in measurement year 2022:

- *Breast Cancer Screening—Total* for the Southeast and Southwest regions.
- *Cervical Cancer Screening* for the Southwest Region—Note that the rate for this measure was above the high performance level in measurement year 2022 in this region.
- *Controlling High Blood Pressure—Total* for the Northwest Region.
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for the Northeast and Northwest regions.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Partnership

Based on the overall assessment of Partnership's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of Partnership's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for Partnership show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that Partnership followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- Partnership performed above the high performance levels for the following measures in measurement year 2022:

  - *Cervical Cancer Screening* for the Southwest Region
  - *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* for the Northeast and Southeast regions
  - *Immunizations for Adolescents—Combination 2* for the Southeast and Southwest regions
  - *Prenatal and Postpartum Care—Postpartum Care* for the Northwest, Southeast, and Southwest regions
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for the Southwest Region
- Based on its performance measure results across all reporting units, Partnership performed best in the Southwest and Southeast regions, where it met or exceeded the minimum performance levels for 10 and nine performance measure rates, respectively, compared to five rates each for the Northeast and Northwest regions.
- HSAG assigned a *High Confidence* level to both of Partnership's 2020–22 PIPs, reflecting that the MCMC plan followed the approved PIP methodologies, achieved improvement, documented data to clearly link improvement to at least one tested intervention, and accurately summarized the key findings and conclusions.
  - Partnership's *Breast Cancer Screening Among Members Living in Rural and Small Counties* Health Equity PIP mobile mammography events and member outreach interventions contributed to improved access to mammograms for eligible members and resulted in more eligible members receiving their recommended breast cancer screenings.
  - Partnership's *Well-Child Visits in the First 15 Months of Life* PIP intervention, offering Saturday clinic appointments, resulted in an increase in the percentage of eligible members who completed the recommended number of well-child visits.

Opportunities for Improvement

- DHCS identified findings within three of the CFR standards during the DHCS compliance review scoring process for Partnership.
- Across all reporting units in measurement year 2022, Partnership performed below the minimum performance levels for 31 of 60 measure rates that HSAG compared to benchmarks (52 percent).
- Performance measure results show that Partnership has opportunities for improvement across all reporting units, with the greatest opportunities for improvement in the Northeast and Northwest regions, where Partnership performed below the minimum performance levels for 10 performance measure rates for each of these reporting units.

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure Partnership meets all CFR standard requirements moving forward.

- For measures for which Partnership performed below the minimum performance levels in measurement year 2022, assess the factors that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Partnership should determine whether the member-, provider-, and community-focused interventions described in Table C.23 need to be revised or abandoned based on intervention evaluation results.
  - Based on measurement year 2022 performance measure results, Partnership should prioritize implementing quality improvement strategies in the Northeast and Northwest regions.

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

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

San Francisco Health Plan

Follow-Up on Prior Year Recommendations

Table C.24 provides EQR recommendations HSAG made to SFHP in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.24 to preserve the accuracy of SFHP's self-reported actions.

Table C.24—SFHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Address the findings from the 2022 A&I Medical Audit of SFHP by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in all categories except Quality Management.	SFHP has worked closely with DHCS to close out the 2022 CAP, providing monthly updates to the CAP. Although there are eight findings that remain open, SFHP has provided evidence and is awaiting official closure on six of those findings. Of the three findings that remain open, two are awaiting Department of Managed Health Care (DMHC) approval prior to CAP implementation, and SFHP is working closely with DHCS and DMHC to resolve those issues. The remaining finding is also the last finding from the 2021 audit to be resolved. Specific actions completed include: ♦ 1.3.1: Closed—The Governing Board and Member Advisory Committee receive regular reporting on grievance and appeal data. ♦ 1.3.2: Open—SFHP is awaiting approval from DMHC prior to implementing a consent form required by DHCS. There is conflicting guidance between the two regulators. SFHP is ready to implement the form once approval is obtained.

2021–22 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	♦ 1.5.1: Closed—SFHP has created a system to disperse delegate information and obtain proof of implementation. ♦ 1.5.2: Open, yet complete—All delegates have submitted ownership and control documents. ♦ 2.1.1: Closed—SFHP revised the Health Information Form/Member Evaluation Tool process to correct the algorithm that identifies new members and gets the forms mailed out in a timely manner. ♦ 2.1.2: Open, yet complete—SFHP selected a new case management vendor and implementation is in progress. The health risk stratification was updated in the current system and is being built in the future system. ♦ 2.1.3: Open, yet complete—SFHP updated the procedure for documenting attempted calls to include the reason for a missed connection. SFHP conducted an audit; process fully implemented. ♦ 2.1.4: Open, related to 2021 CAP item, still open—SFHP formed a workgroup, updated the methodology to catch and report on IHAs, and the MCMC plan is reestablishing reporting to delegates. Staffing changes prevented this from being fully implemented. ♦ 4.1.1: Closed—SFHP revised the grievance process to include a review of proposed language at weekly Grievance Review Committee meetings. SFHP conducted an audit. ♦ 4.1.2: Closed—The Governing Board and Member Advisory Committee receive regular reporting on grievance and appeal data.

2021–22 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	♦ 4.1.3: Closed—SFHP created a process to address issues with delayed or nonresponsive providers in the grievance investigative procedure. SFHP added this to the audit process. ♦ 4.1.4: Closed—SFHP received approval and implemented a process to notify members of delays in grievance responses. SFHP conducted an audit. ♦ 4.1.5: Open—Awaiting regulatory approval from DMHC to implement a new form for written member consent. Conflicting requirements between DHCS and DMHC are creating a delay in implementation. ♦ 4.3.1: Open, yet complete—SFHP implemented a contractor background check process and provided evidence of implementation. ♦ 5.1.1: Open, yet complete—The PQI process was updated to include progress reports and tracking of cases. Evidence of implementation provided.
2. Continue to work with DHCS to fully resolve all findings from the 2021 A&I Medical Audit of SFHP.	There is one remaining finding for IHAs that remains open until SFHP can implement the entirety of the CAP. This was also a finding in 2022 and 2023. The MCMC plan has created an active workgroup to resolve the issues with IHA completion for new members, has updated the reporting methodology, and is working closely with DHCS to demonstrate compliance.
3. For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in SFHP performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors. As part of this	SFHP created the Quality Workgroup to address this issue. The group completed a full analysis of the issue and has started the following interventions: ♦ For measurement years 2020 and 2021, SFHP identified the disparities across race and ethnicity in the populations for both *Well-Child Visits in the First 30 Months of*

2021–22 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
assessment, SFHP should determine whether interventions the plan previously implemented need to be revised or abandoned based on intervention evaluation results.	*Life* measures. SFHP has segmented the two populations based on measurement year 2021 results into population segments of age group, race/ethnicity, census tract/geographic area, language, assigned PCP, and distance from PCP. SFHP can use this segmentation to identify priority and target populations. ♦ SFHP staff members have begun coalition building with providers and community-based organizations to focus on preventive health child-focused work. Current connections include select neighborhood and PCP clinics which see a high number of SFHP child members, Head Start and Early Head Start programs, and Family Resource Centers. ♦ SFHP hired a child and family program manager to oversee the management of improvement activities related to child and adolescent health. This position had been open for approximately one year as the previous program manager left the organization. This is a niche role that took an extended period of time to fill. ♦ SFHP increased the frequency of member communications and removed a barrier to obtaining incentive payments by eliminating the requirement for a physician signature on the incentive forms if the member attended the first six visits. ♦ SFHP is working closely with DHCS to demonstrate improvements in this area.

Assessment of SFHP's Self-Reported Actions

HSAG reviewed SFHP's self-reported actions in Table C.24 and determined that SFHP adequately addressed the 2021–22 EQR recommendations. SFHP indicated that it has worked closely with DHCS to close out the CAP for the 2022 A&I Medical Audit and provided details regarding the status of each open and closed finding from the audit. SFHP indicated that one finding remains open from the 2021 A&I Medical Audit, and the MCMC plan is working closely with DHCS regarding the steps SFHP is taking to demonstrate full compliance with the requirements.

SFHP created a workgroup to address the MCMC plan performing below the minimum performance levels for both *Well-Child Visits in the First 30 Months of Life* measures in measurement year 2021. SFHP reported the following efforts to improve performance on both measures:

- Used data to identify priority and target populations for each measure.
- Began collaborating with providers and community-based organizations that focus on children's preventive health issues.
- Hired a child and family program manager to oversee the MCMC plan's child and adolescent improvement activities.
- Increased member communications and eliminated an identified barrier for members to receive incentive payments for completing the first six well-child visits.

The strategies SFHP implemented may have contributed to the rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure moving from below the minimum performance level in measurement year 2021 to above the minimum performance level in measurement year 2022.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for SFHP

Based on the overall assessment of SFHP's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of SFHP's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for SFHP show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that SFHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- SFHP performed above the high performance levels for the following measures in measurement year 2022:
  - *Breast Cancer Screening—Total*
  - *Childhood Immunization Status—Combination 10*
  - *Controlling High Blood Pressure—Total*
  - *Immunizations for Adolescents—Combination 2*
  - *Prenatal and Postpartum Care—Postpartum Care*
- While HSAG assigned a *Low Confidence* level to SFHP's 2020–22 *Breast Cancer Screening Among African-American Members* Health Equity PIP, the MCMC plan followed the approved PIP methodology and achieved statistically significant improvement in the SMART Aim measure rate.
- While HSAG assigned a *No Confidence* level to SFHP's 2020–22 *Well-Child Visits in the First 15 Months of Life* PIP, reflecting that the MCMC plan did not follow the approved PIP methodology, SFHP noted lessons learned from conducting the PIP and indicated steps the MCMC plan will take moving forward to improve well-child visit rates.

Opportunities for Improvement

- DHCS identified findings within six of the CFR standards during the DHCS compliance review scoring process for SFHP.
- SFHP performed below the minimum performance levels in measurement year 2022 for the following two of 15 measure rates that HSAG compared to benchmarks (13 percent):
  - *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure SFHP meets all CFR standard requirements moving forward.
- Assess the factors that contributed to SFHP performing below the minimum performance levels in measurement year 2022 for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* and *Well-Child Visits in the First 30 Months of*

Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits measures and implement quality improvement strategies that target the identified factors.

- For the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure, assess whether the provider education and member outreach strategies described in Table C.24 need to be revised to increase the percentage of members turning 15 months old who complete six or more well-child visits.

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

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

Santa Clara Family Health Plan

Follow-Up on Prior Year Recommendations

Table C.25 provides EQR recommendations HSAG made to SCFHP in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendations. Please note that HSAG made minimal edits to Table C.25 to preserve the accuracy of SCFHP's self-reported actions.

Table C.25—SCFHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
1. Continue to work with DHCS to fully resolve all findings from the 2020 and 2021 A&I Medical Audits of SCFHP.	Findings from the 2020 and 2021 A&I Medical Audits have been closed.
2. Address the findings from the 2022 A&I Medical Audit of SCFHP by implementing the actions recommended by A&I, paying particular attention to the repeat finding A&I identified in the Access and Availability of Care category.	SCFHP has been working with DHCS to address the findings from the 2022 A&I Medical Audit. SCFHP has been providing monthly updates to DHCS for review. The repeat finding in the Access and Availability of Care category was corrected when the 2021 audit CAPs were closed.
3. For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in SCFHP performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors.	For both *Well-Child Visits in the First 30 Months of Life* measures, COVID-19 played a role in SCFHP's low performance; however, the MCMC plan identified other trends and issues. SCFHP found that nearly half of the noncompliant members had completed five of six visits, or for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure, one of two visits. Review of the data showed that the newborn visit was completed; however, the visit was not captured due to it being recorded under the mother's name. In other instances, visits were completed, but the visit was outside the

2021–22 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendations
	compliance requirement due to scheduling availability. Additionally, Kaiser (SCFHP's plan partner) had low compliance rates for both measures. In discussions with Kaiser, we found that Kaiser was not requiring a nine-month visit for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure. Interventions for calendar year 2022 included provider education to correct missing or incorrect coding processes, identification of missing visits prior to the member's birthday, member outreach, member incentives, and data enhancements to link the mom to the baby. SCFHP is also working with Kaiser to implement a plan to incorporate a nine-month visit.

Assessment of SCFHP's Self-Reported Actions

HSAG reviewed SCFHP's self-reported actions in Table C.25 and determined that SCFHP adequately addressed the 2021–22 EQR recommendations. SCFHP reported that DHCS has closed all findings from the 2020 and 2021 A&I Medical Audits and that the MCMC plan is working with DHCS to address the findings from the 2022 audit.

SCFHP indicated that in addition to COVID-19 contributing to the MCMC plan performing below the minimum performance levels in measurement year 2021 for both *Well-Child Visits in the First 30 Months of Life* measures, data capture issues affected the measures' rates as well as one of the plan partners not requiring a nine-month visit for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure. To address these issues, SCFHP:

- Conducted provider education.
- Identified members who were missing visits prior to their birthday.
- Conducted member outreach.
- Offered member incentives.
- Made data process enhancements.
- Initiated working with the plan partner to implement nine-month visits.

The strategies SCFHP implemented may have contributed to the rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure moving from below the minimum performance level in measurement year 2021 to above the minimum performance level in measurement year 2022.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for SCFHP

Based on the overall assessment of SCFHP's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of SCFHP's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for SCFHP show that the MCMC plan was fully compliant with all but one of the 14 CFR standards.
- The HSAG auditor determined that SCFHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- SCFHP performed above the high performance level in measurement year 2022 for the *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure.
- HSAG assigned a *Moderate Confidence* level to SCFHP's 2020–22 *Lead Screening in Children* PIP, reflecting that the MCMC plan followed the approved PIP methodology, achieved improvement, and documented data to clearly link improvement to at least one tested intervention. SCFHP's provider-focused PIP intervention resulted in an increase in the number of eligible members completing a blood lead screening.
- While HSAG assigned a *Low Confidence* level to SCFHP's 2020–22 *Adolescent Well-Care Visits in Network 20* Health Equity PIP, the MCMC plan followed the approved PIP methodology.

Opportunities for Improvement

- DHCS identified findings within one of the CFR standards during the DHCS compliance review scoring process for SCFHP.

- SCFHP performed below the minimum performance level in measurement year 2022 for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure.

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure SCFHP meets all CFR standard requirements moving forward.
- Assess the factors that contributed to SCFHP performing below the minimum performance level in measurement year 2022 for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure and implement quality improvement strategies that target the identified factors. As part of its assessment, the MCMC plan should determine whether the member- and provider-focused interventions described in Table C.25 need to be revised to increase the percentage of members turning 15 months old who complete six or more well-child visits.

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

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

SCAN Health Plan

Follow-Up on Prior Year Recommendation

Table C.26 provides the EQR recommendation HSAG made to SCAN in the 2021–22 EQR technical report, along with the MCMC plan's self-reported actions taken through June 30, 2023, that address the recommendation. Please note that HSAG made minimal edits to Table C.26 to preserve the accuracy of SCAN's self-reported actions.

Table C.26—SCAN's Self-Reported Follow-Up on the External Quality Review Recommendation from the July 1, 2021, through June 30, 2022, External Quality Review Technical Report

2021–22 External Quality Review Recommendation Directed to SCAN	Self-Reported Actions Taken by SCAN during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
1. Address the findings from the 2022 A&I Medical Audit of SCAN by implementing the actions recommended by A&I.	**1.2.1 Notice of Action Benefit Determination Contact Information**—SCAN did not ensure NOA notifications submitted to providers contained the name and direct telephone number of the MCMC plan decision maker. SCAN took the following actions to address this finding: ♦ In February 2022, developed a fax coversheet to include the decision maker's name and contact information for provider written notification of adverse decisions. ♦ In March 2022, implemented a new fax coversheet with the Integrated Denial Notice/Coverage Decision letter. ♦ In March 2022, updated and implemented an adverse decision provider notification process, including notification, monitoring, and auditing processes. **1.2.2 State Fair Hearing Time Frame Extension**—SCAN did not ensure written NOA attachments included information to notify members of the extended time frame to

2021–22 External Quality Review Recommendation Directed to SCAN	Self-Reported Actions Taken by SCAN during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	request a State fair hearing. SCAN took the following actions to address this finding: ♦ In October 2022, developed a new denial notice template to include required language and State fair hearing time frame and obtained compliance and DHCS approval. ♦ In October 2022, implemented a new denial notice (English only/manual process). ♦ In November 2022, deactivated the current denial notice in the system (translated languages; dependent on receipt of translations). ♦ In December 2022, implemented a new denial notice process (translated languages/manual process). ♦ In February 2023, integrated a new denial notice into the system (all languages). **1.5.1 Oversight of Utilization Management Delegate—**SCAN did not perform continuous monitoring of delegated prior authorizations to ensure the provision of Medi-Cal covered services for dual eligible members. SCAN took the following actions to address this finding: ♦ In January 2023, updated the monthly report to identify delegate unfavorable decisions in which members may have been denied services covered by Medi-Cal, developed a process for report review and the decision process, and retrained medical groups on using the informational/carve out letter. ♦ In February 2023, updated and received approval for an oversight audit tool. ♦ In March 2023, initiated conducting oversight audits. If a provider partner is found to be noncompliant, SCAN will

2021–22 External Quality Review Recommendation Directed to SCAN	Self-Reported Actions Taken by SCAN during the Period of July 1, 2022–June 30, 2023, that Address the External Quality Review Recommendation
	request the provider to conduct a root cause analysis and implement a CAP to ensure provider partners rectify their processes. **3.8.1 Physician Certification Statement Form**—SCAN did not obtain required PCS forms prior to the provision of transportation services. The MCMC plan did not ensure compliance with APL 17-010. To address this finding, SCAN executed a new vendor contract in 2023. **3.8.2 Transportation Provider Medi-Cal Enrollment**—SCAN did not ensure subcontracted transportation providers were enrolled in the Medi-Cal program. To address this finding, SCAN executed a new vendor contract in 2023.

Assessment of SCAN's Self-Reported Actions

HSAG reviewed SCAN's self-reported actions in Table C.26 and determined that SCAN adequately addressed the 2021–22 EQR recommendation. SCAN provided detailed descriptions of the actions the MCMC plan has taken to address each finding from the 2022 A&I Medical Audit.

2022–23 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for SCAN

Based on the overall assessment of SCAN's delivery of quality, accessible, and timely care through the 2022–23 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan. Note that all of SCAN's activities and services affect the quality, accessibility, and timeliness of care delivered to its members. When applicable, HSAG indicates instances in which the MCMC plan's performance affects one specific aspect of care more than another.

Strengths

- DHCS' compliance review scores for SCAN show that the MCMC plan was fully compliant with most CFR standards.
- The HSAG auditor determined that SCAN followed the appropriate specifications to produce valid performance measure rates for measurement year 2022 and identified no issues of concern.
- SCAN performed above the high performance levels in measurement year 2022 for the following three measure rates that HSAG compared to benchmarks:
  - *Breast Cancer Screening—Total*
  - *Controlling High Blood Pressure—Total*
  - *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*
- While HSAG assigned a *No Confidence* level to both of SCAN's 2020–22 PIPs, reflecting that the MCMC plan did not follow the approved PIP methodologies, SCAN noted lessons learned from conducting both PIPs and indicated that the MCMC plan will apply these lessons learned moving forward.

Opportunities for Improvement

- DHCS identified findings within two of the CFR standards during the DHCS compliance review scoring process for SCAN.

2022–23 External Quality Review Recommendations

- Work with DHCS to resolve the identified findings from DHCS' compliance review scoring process to ensure SCAN meets all CFR standard requirements moving forward.

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