Managed Care Program Annual Report (MCPAR) for California: California Department of Health Care Services: Medi-Cal Managed Care

Due date	Last edited	Edited by	Status
06/28/2024	06/28/2024	Farrah Samimi	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	California
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Farrah Samimi
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	Farrah.Samimi@dhcs.ca.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Farrah Samimi
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	farrah.samimi@dhcs.ca.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/28/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2023
A6	**Program name** Auto-populated from report dashboard.	California Department of Health Care Services: Medi-Cal Managed Care

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Indicator	Response
Plan name	Aetna Better Health of California
	AIDS Healthcare Foundation
	Alameda Alliance for Health
	Anthem Blue Cross
	Blue Shield of California Promise
	California Health and Wellness Plan
	CalOptima
	CalViva Health
	CenCal Health
	Central California Alliance for Health
	Community Health Group
	Contra Costa Health Plan
	Gold Coast Health Plan
	Health Net Community Solutions
	Health Plan of San Joaquin
	Health Plan of San Mateo
	Inland Empire Health Plan
	Kaiser Permanente
	Kern Health Systems
	L.A. Care Health Plan
	Molina Healthcare of California
	Partnership Health Plan of California
	San Francisco Health Plan
	Santa Clara Family Health Plan
	SCAN Health Plan

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

	Indicator	Response
	BSS entity name	Maximus

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	14,887,144
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	13,465,165

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	EQRO

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter 'No PI activities were performed during the reporting period' as your response. 'N/A' is not an acceptable response.	The State's program integrity activities involve reviewing encounter data and claims for anomalies and questionable billing patterns under both the managed care plan (MCP) model and fee-for-service (FFS) model. The State performs data analytics to detect fraudulent activities, suspicious providers, and emerging fraud trends within the Medi-Cal program. Actionable leads generated from data analytics and case development efforts are then prioritized and investigated for suspected fraud, waste and abuse. The conclusion of these investigations may result in criminal referrals to the State's Medicaid Fraud Control Unit (MFCU) and/or administrative actions (e.g., educational letter, sanctions, penalties, overpayment recovery) taken against the provider. Recent cases involve prescription drugs and hospice services. In addition to requiring each MCP to maintain a comprehensive program integrity plan to combat fraud, waste and abuse; the State conducts annual managed care contract compliance audits. The results of these audits are used in part by the State to achieve its managed care contract oversight and monitoring objectives. Audit results are used to pursue Corrective Action Plans (CAP) from MCPs, and support sanctions and penalties imposed on non-compliant plans when warranted.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Medi-Cal Managed Care Contract, Exhibit E, Attachment 2, Provision 35, Treatment of Recoveries. Overpayment Standards are in All Plan Letter (APL) 17-003 (https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-003.pdf)

BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	The MCP shall retain all overpayment recoveries less than $25 million. For overpayments of $25 million or more, the State and the MCP will share the recovery amount equally.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	Per APL 23-011, overpayments of any amount that are related to fraud, waste, or abuse are reported by plans to DHCS through their Managed Care Operations Contract Manager and Audits and Investigation's PIU inbox. Additionally, all overpayments, including but not limited to overpayments due to fraud, waste, or abuse, to a single provider that are equal to or more than $25 million are reported by plans to their Contract Manager. The value of all overpayments and any recouped overpayments are reported to the Capitated Rates Development Division in the Rate Development Template (RDT) as part of the rate development process.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	BSS sends a daily enrollment file to the State. The State provides a file back to the BSS daily for reconciliation between the State and BSS. The BSS provides plans with State accepted enrollments weekly. The State also provides plans with a daily and monthly 834 file that can be used to reconcile enrollments between the State and Plans.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No

BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	Yes
BX.8b	**Federal database checks: Summarize instances of exclusion** Summarize the instances and whether the entity was notified as required in 438.602(d). Report actions taken, such as plan-level sanctions and corrective actions.	As part of the State-level Medi-Cal enrollment process, DHCS reviews providers against the exclusionary databases (i.e. Social Security Administration's Death Master File, National Plan and Provider Enumeration System, List of Excluded Individuals/Entities, CMS' Medicare Exclusion Database, DHCS' Suspended and Ineligible Provider List, and Restricted Provider Database) upon initial enrollment and again at re-enrollment within five years. DHCS also requires MCPs to check exclusionary databases regularly and no less than monthly as per All Plan Letter (APL) 21-003 and APL 22-013 with triggering actions upon discovery. DHCS' audit program contains scope that allows DHCS to review MCPs' credentialing files to confirm that providers are appropriately licensed/certified/registered, have good standing in the Medicare and Medicaid/Medi-Cal programs, and possess a valid NPI number. Additionally, during the state's federal database checks, DHCS informs Managed Care Plans of provider NPIs that were invalid in the National Plan and Provider Enumeration System.
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to	Yes

	§455.104 and required by 42 CFR 438.602(g)(3).	
BX.9b	**Website posting of 5 percent or more ownership control: Link** What is the link to the website? Refer to 42 CFR 602(g)(3).	https://www.healthcareoptions.dhcs.ca.gov/content/dam/digital/united-states/california/ca-hco/documents/english/2023%20Program%20Integrity%20Report.pdf
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter 'No such audits were conducted during the reporting year' as your response. 'N/A' is not an acceptable response.	Mercer (contractor) performs periodic audits of financial data submitted by each MCP, pursuant to 42 CFR 438.602(e) on DHCS' behalf. DHCS is fully compliant with both 42 CFR 438.602(e) and 438.602.(g)(4). DHCS has continued to perform Rate Develpment Template audits on a rolling basis to ensure that the requirements set forth in 42 CFR 438.602(e) are met. Location of Periodic Audits: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDFinancialReports.aspx Location of Encounter Data Validation Study Reports: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEDV.aspx

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Multiple dates - the State holds current contracts with plans that have been established from back in 2003 up to 2018.
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	2003-2018
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Dental Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	Institutional long-term care under adult subacute care was covered by Medi-Cal managed care plans in COHS and CCI counties only until December 31, 2023. Effective January 1, 2024, this benefit is covered in all counties with no variation in long-term benefits. Dental is covered through a pilot program for one managed care plan, Health Plan of San Mateo.
C1I.5	**Program enrollment**	13,465,165

	Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter 'There were no major changes to the population or benefits during the reporting year' as your response. 'N/A' is not an acceptable response.	Effective January 1, 2023, Managed Care Plans in all counties cover Medically Necessary Skilled Nursing Facility services. Additionally, January 1, 2024, all MCPs became responsible for long-term care benefits in the following settings: Intermediate Care Facility for Developmentally Disabled (ICF-DD); ICF-DD/Habilitative; ICF-DD/Nursing; Subacute Care Facility, including a distinct part of a hospital or freestanding facility; and Pediatric Subacute Facility. Effective January 1, 2023, MCPs are required to provide doula services for prenatal, perinatal and postpartum Members. Enhanced Care Management (ECM)/In-Lieu Of Services (ILOS) went live for the following populations of focus: Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization; Adult Nursing Facility Residents Transitioning to the Community; Adults without Dependent Children/Youth Living with Them Experiencing Homelessness; and Children & Youth Populations of Focus.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Other, specify – Internal State staff review timeliness of initial data submissions, use of correct file format, provider ID field completeness, and overall data accuracy. Contractor (Mercer) staff leverage Encounter Data Stoplight reports to evaluate completeness by comparing the amount of utilization reported through each MCP's rate development template and the amount of encounter data reported to DHCS.
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Two-Plan CCI Boilerplate: Exhibit A, Attachment 3 Management Information System, Provision 2, Encounter Data Reporting, Paragraphs A-H
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality	Two-Plan CCI Boilerplate: Exhibit E, Attachment 2 Program Terms and Conditions, Provision 17, Sanctions

	standards. Use contract section references, not page numbers.	
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter 'The state did not experience any barriers to collecting or validating encounter data during the reporting year' as your response. 'N/A' is not an acceptable response.	The state has had barriers collecting and/or validating managed care plan encounter data for services transitioning from Fee-For-Service into Managed Care. To address this issue, the state has continued to institute its limited term delivery system reform directed payments.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, and any instances of suspected or alleged abuse, neglect, exploitation, and/or mistreatment.
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	30 calendar days
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	72 hours
C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the	For standard grievances: 30 calendar days For expedited grievances: 72 hours

		day the MCO, PIHP or PAHP receives the grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter 'No challenges were encountered' as your response. 'N/A' is not an acceptable response.	There is a shortage of providers in rural areas of the state and due to the geographic nature of specific counties, it is challenging for Plans to and in some cases, not possible, meet state defined network adequacy time or distance standards.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	When the State identifies a service area in which the Plan does not meet time or distance standards, the Plan must submit an Alternative Access Standards (AAS) request for time and distance in these rural areas. The State works with the Plans on these AAS requests to confirm they contract or attempt to contract with the closest available provider, and require that the plan allow its members to obtain out-of-network (OON) access which ensures member protections and avoids disruption in the services provided. The State makes available other MCP networks to assist with contracting efforts. The State also uses Directed Payments as a means to establish clear provider payment rates and thus encourage network agreements between plans and providers.

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Access measure total count: 41

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 41

C2.V.2 Measure standard

30 minutes or 10 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 41

C2.V.2 Measure standard

90 minutes or 60 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty Care	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

3 / 41

C2.V.2 Measure standard

75 minutes or 45 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty Care	Small counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

60 minutes or 30 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty Care	Medium Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

30 minutes or 15 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty Care	Dense Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

30 minutes or 10 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Obstetrics/Gynecology/Primary Care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90 minutes or 60 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Obstetrics/Gynecology Specialty Care	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

8 / 41

C2.V.2 Measure standard

75 minutes or 45 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Obstetrics/Gynecology Specialty Care	Small counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

60 minutes or 30 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Obstetrics/Gynecology Specialty Care	Medium counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

30 minutes or 15 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Obstetrics/Gynecology Specialty Care	Dense counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

30 minutes or 15 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Hospital	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90 minutes or 60 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Non-Specialty Mental Health Providers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

75 minutes or 45 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Non-Specialty Mental Health	Small counties	Adult and pediatric

Providers

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

60 minutes or 30 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Non-Specialty Mental Health Providers	Medium Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

30 minutes or 15 miles from any Member or anticipated Member's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Non-specialty Mental Health Providers	dense counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Within 10 business days of the request for appointment

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Within 15 business days of the request for appointment

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty Care	Statewide	All applicable populations

C2.V.7 Monitoring Methods

External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Within 10 business days of the request for appointment

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Obstetrics/Gynecology Primary Care	Statewide	All applicable populations

C2.V.7 Monitoring Methods

External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Within 15 business days of the request for appointment

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Obstetrics/Gynecology Specialty Care	Statewide	All applicable populations

C2.V.7 Monitoring Methods

External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

20 / 41

C2.V.2 Measure standard

Non-urgent: Within 36 business days of the request for appointment

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental Providers	Statewide	All applicable populations

C2.V.7 Monitoring Methods

External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

21 / 41

C2.V.2 Measure standard

Preventive: Within 40 business days of the request for appointment

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental Providers	Statewide	All populations

C2.V.7 Monitoring Methods

External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

22 / 41

C2.V.2 Measure standard

Within 10 business days of the request for appointment

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Non-Specialty Mental Health Providers	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

23 / 41

C2.V.2 Measure standard

Within 14 calendar days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-SNF	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

24 / 41

C2.V.2 Measure standard

Within 14 calendar days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-SNF	Small counties	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Policy and Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

25 / 41

C2.V.2 Measure standard

Within 7 business days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-SNF	Medium counties	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Policy and Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

26 / 41

C2.V.2 Measure standard

Within 5 business days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-SNF	Dense counties	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Policy and Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

27 / 41

C2.V.2 Measure standard

Within 14 calendar days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Policy and Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

28 / 41

C2.V.2 Measure standard

Within 14 calendar days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-Intermediate Care Facility/Developmentally	Small counties	Adult and pediatric

Disabled (ICF-DD)

C2.V.7 Monitoring Methods

Plan Policy and Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

29 / 41

C2.V.2 Measure standard

Within 7 business days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Medium counties	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Policy and Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

30 / 41

C2.V.2 Measure standard

Within 5 business days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Dense counties	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Policy and Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Capacity cannot decrease in aggregate statewide below April 2012 level

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-Community Based Adult Services (CBAS)	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Policy and Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Capacity cannot decrease in aggregate statewide below April 2012 level

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-Community Based Adult Services (CBAS)	Small counties	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Policy and Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

33 / 41

C2.V.2 Measure standard

Capacity cannot decrease in aggregate statewide below April 2012 level

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-Community Based Adult Services (CBAS)	Medium counties	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Policy and Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

34 / 41

C2.V.2 Measure standard

Capacity cannot decrease in aggregate statewide below April 2012 level

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-Community Based Adult Services (CBAS)	Dense counties	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Policy and Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 35 / 41

C2.V.2 Measure standard

10 minutes from the time the call is placed

C2.V.3 Standard type

Ease of getting a timely appointment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Medi-Cal Managed Care Health Plan Call Center	Statewide	Adult

C2.V.7 Monitoring Methods

External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 36 / 41

C2.V.2 Measure standard

1 Full-Time Equivalent PCP to 2,000 Members

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

37 / 41

C2.V.2 Measure standard

1 Full-Time Equivalent Physician to every 1,200 Members

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Total Network Physicians	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

38 / 41

C2.V.2 Measure standard

Outpatient Mental Health Provider to Member Ratios. This calculation is based on mental health utilization for the previous year

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Outpatient Mild-to-Moderate Mental Health Services	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

39 / 41

C2.V.2 Measure standard

Required to contract with at least one Mandatory Provider Type where available in each county in which the plan operates Local Initiative MCPs are required to offer to contract with all available Federally Qualified Health Center (FQHCs) and Rural Health Clinic (RHCs) in each of their counties

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
MPTs include: Federally Qualified Health Center , Rural Health Clinic, Freestanding Birthing Center, Licsensed Midwife and Certified Nurse Midwife	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

40 / 41

C2.V.2 Measure standard

Required to offer to contract with all available Indian Health Care Provider (IHCP) in each county in which the MCP operates

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
IHCP	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

41 / 41

C2.V.2 Measure standard

Required to make good faith efforts to contract with at least one cancer center within their contracted Provider Networks within each county in which the MCP operates.

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Cancer Center	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Provider roster review

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	HCO Website: https://www.healthcareoptions.dhcs.ca.gov/
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	In Person support is provided by Enrollment Service Representatives (ESRs) who provide education and outreach through face-to-face presentations, including in-person choice counseling, and outreach events. ESRs assist applicants and beneficiaries in understanding, selecting, and using managed care health plans. Presentation Site locations and schedules can be found on the HCO website or by calling the Telephone Call Center (TCC). ESR/Presentation Site locations ensure disabled, hearing and/or visually impaired applicants or beneficiaries understand their health care options by providing presentations and informing materials in alternate formats that comply with the Americans with Disability Act (ADA). Presentation Site facilities are physically accessible to individuals with disabilities pursuant to section 1557 of the Patient Protection and Affordable Care Act (45 CFR 92.203). Beneficiary support systems assist disabled, hearing and/or visually impaired applicants or beneficiaries to understand their health care options by providing presentations and informing materials in alternate formats that comply with ADA. Mailings are mailed to beneficiaries in all threshold languages, as well as in Alternative Formats for persons with disabilities i.e. Braille, Large Print, and Audio CD. Additionally, in-person support can be scheduled with sign language interpreters for beneficiaries who need it. TCC provides auxiliary aids such as TTY/TDD.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	BSS has a State approved and contractually required complaint and grievance process. Beneficiary complaints on systemic issues, including issues related to LTSS program data, are documented, investigated, and delivered to the DHCS for research and resolution.

C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	DHCS monitors activities objectively and systematically, measuring and reporting on operation performance, as well as reviewing operations policies and procedures for the purpose of providing recommendations for improvements in the performance of BSS. DHCS ensures BSS performance standards are regularly monitored, evaluated, and revised to ensure compliance of the Telephone Call Center, Educations and Outreach, Informing Materials, Enrollment/Disenrollment Processing, Complaints and Grievance Resolution, Quality Management Program, Reports Reporting, Records Retention and Retrieval, Security and Confidentiality. In addition to the BSS being required to maintain an ISO 9001 certified Quality Management System, the BSS is required to meet stringent SLAs, which is monitored by DHCS. Additionally, BSS performance is monitored and evaluated by beneficiary feedback on the quality of service provided by the BSS. Data is collected and reviewed through a Caller Satisfaction Evaluation Tool.DHCS monitors activities objectively and systematically, measuring and reporting on operation performance, as well as reviewing operations policies and procedures for the purpose of providing recommendations for improvements in the performance of BSS. DHCS ensures BSS performance standards are regularly monitored, evaluated, and revised to ensure compliance of the Telephone Call Center, Educations and Outreach, Informing Materials, Enrollment/Disenrollment Processing, Complaints and Grievance Resolution, Quality Management Program, Reports Reporting, Records Retention and Retrieval, Security and Confidentiality. In addition to the BSS being required to maintain an ISO 9001 certified Quality Management System, the BSS is required to meet stringent service level agreements, which is monitored by DHCS. Additionally, BSS performance is monitored and evaluated by beneficiary feedback on the quality of service provided by the BSS. Data is collected and reviewed through a Caller Satisfaction Evaluation Tool.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	Yes

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Aetna Better Health of California** 57,817 **AIDS Healthcare Foundation** 868 **Alameda Alliance for Health** 346,712 **Anthem Blue Cross** 1,032,751 **Blue Shield of California Promise** 152,106 **California Health and Wellness Plan** 256,433 **CalOptima** 933,383 **CalViva Health** 430,466 **CenCal Health** 226,971 **Central California Alliance for Health** 405,313 **Community Health Group** 354,143 **Contra Costa Health Plan** 267,207 **Gold Coast Health Plan**

243,481

Health Net Community Solutions

1,672,625

Health Plan of San Joaquin

438,063

Health Plan of San Mateo

143,203

Inland Empire Health Plan

1,627,608

Kaiser Permanente

217,172

Kern Health Systems

363,265

L.A. Care Health Plan

2,557,912

Molina Healthcare of California

553,225

Partnership Health Plan of California

661,200

San Francisco Health Plan

184,543

Santa Clara Family Health Plan

318,667

SCAN Health Plan

20,021

D1I.2	**Plan share of Medicaid**	**Aetna Better Health of California**

What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment?

- Numerator: Plan enrollment (D1.I.1)
- Denominator: Statewide Medicaid enrollment (B.I.1)

0.4%

AIDS Healthcare Foundation

0%

Alameda Alliance for Health

2.3%

Anthem Blue Cross

6.9%

Blue Shield of California Promise

1%

California Health and Wellness Plan

1.7%

CalOptima

6.3%

CalViva Health

2.9%

CenCal Health

1.5%

Central California Alliance for Health

2.7%

Community Health Group

2.4%

Contra Costa Health Plan

1.8%

Gold Coast Health Plan

1.6%

Health Net Community Solutions

11.2%

Health Plan of San Joaquin

2.9%

Health Plan of San Mateo

1%

Inland Empire Health Plan

10.9%

Kaiser Permanente

1.5%

Kern Health Systems

2.4%

L.A. Care Health Plan

17.2%

Molina Healthcare of California

3.7%

Partnership Health Plan of California

4.4%

San Francisco Health Plan

1.2%

Santa Clara Family Health Plan

2.1%

SCAN Health Plan

0.1%

D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid	**Aetna Better Health of California** 0.4% **AIDS Healthcare Foundation**

enrollment in any type of managed care?

- Numerator: Plan enrollment (D1.I.1)
- Denominator: Statewide Medicaid managed care enrollment (B.I.2)

0%

Alameda Alliance for Health

2.6%

Anthem Blue Cross

7.7%

Blue Shield of California Promise

1.1%

California Health and Wellness Plan

1.9%

CalOptima

6.9%

CalViva Health

3.2%

CenCal Health

1.7%

Central California Alliance for Health

3%

Community Health Group

2.6%

Contra Costa Health Plan

2%

Gold Coast Health Plan

1.8%

Health Net Community Solutions

12.4%

Health Plan of San Joaquin

3.3%

Health Plan of San Mateo

1.1%

Inland Empire Health Plan

12.1%

Kaiser Permanente

1.6%

Kern Health Systems

2.7%

L.A. Care Health Plan

19%

Molina Healthcare of California

4.1%

Partnership Health Plan of California

4.9%

San Francisco Health Plan

1.4%

Santa Clara Family Health Plan

2.4%

SCAN Health Plan

0.1%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Aetna Better Health of California** 104.85% **AIDS Healthcare Foundation** 105.26% **Alameda Alliance for Health** 93.11% **Anthem Blue Cross** 87.44% **Blue Shield of California Promise** 92.67% **California Health and Wellness Plan** 91.12% **CalOptima** 94.18% **CalViva Health** 94.57% **CenCal Health** 94.95% **Central California Alliance for Health** 90% **Community Health Group** 102.44% **Contra Costa Health Plan** 90.26% **Gold Coast Health Plan**

88.81%

Health Net Community Solutions

88.25%

Health Plan of San Joaquin

92.04%

Health Plan of San Mateo

88.63%

Inland Empire Health Plan

93.45%

Kaiser Permanente

103.62%

Kern Health Systems

91.87%

L.A. Care Health Plan

98.55%

Molina Healthcare of California

83.69%

Partnership Health Plan of California

91.79%

San Francisco Health Plan

91.85%

Santa Clara Family Health Plan

94.6%

SCAN Health Plan

91.15%

D1II.1b	**Level of aggregation**	**Aetna Better Health of California**

What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one.
As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.

Statewide all programs & populations

AIDS Healthcare Foundation

Statewide all programs & populations

Alameda Alliance for Health

Statewide all programs & populations

Anthem Blue Cross

Statewide all programs & populations

Blue Shield of California Promise

Statewide all programs & populations

California Health and Wellness Plan

Statewide all programs & populations

CalOptima

Statewide all programs & populations

CalViva Health

Statewide all programs & populations

CenCal Health

Statewide all programs & populations

Central California Alliance for Health

Statewide all programs & populations

Community Health Group

Statewide all programs & populations

Contra Costa Health Plan

Statewide all programs & populations

Gold Coast Health Plan

Statewide all programs & populations

Health Net Community Solutions

Statewide all programs & populations

Health Plan of San Joaquin

Statewide all programs & populations

Health Plan of San Mateo

Statewide all programs & populations

Inland Empire Health Plan

Statewide all programs & populations

Kaiser Permanente

Statewide all programs & populations

Kern Health Systems

Statewide all programs & populations

L.A. Care Health Plan

Statewide all programs & populations

Molina Healthcare of California

Statewide all programs & populations

Partnership Health Plan of California

Statewide all programs & populations

San Francisco Health Plan

Statewide all programs & populations

Santa Clara Family Health Plan

Statewide all programs & populations

SCAN Health Plan

Statewide all programs & populations

D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this	**Aetna Better Health of California** Yes. For rating period CY 2021, the State requires a separate MLR for its MLTSS

program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable.
See glossary for the regulatory definition of MLR.

population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

N/A

Anthem Blue Cross

Yes. For rating period CY 2021, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

Blue Shield of California Promise

Yes. For rating period CY 2021, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

California Health and Wellness Plan

N/A

CalOptima

Yes. For rating period CY 2021, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

CalViva Health

N/A

CenCal Health

N/A

Central California Alliance for Health

N/A

Community Health Group

Yes. For rating period CY 2021, the State requires a separate MLR for its MLTSS

population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

Contra Costa Health Plan

N/A

Gold Coast Health Plan

N/A

Health Net Community Solutions

Yes. For rating period CY 2021, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

Health Plan of San Joaquin

N/A

Health Plan of San Mateo

Yes. For rating period CY 2021, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

Inland Empire Health Plan

Yes. For rating period CY 2021, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

Kaiser Permanente

Yes. For rating period CY 2021, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

Kern Health Systems

N/A

L.A. Care Health Plan

Yes. For rating period CY 2021, the State requires a separate MLR for its MLTSS

population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

Molina Healthcare of California

Yes. For rating period CY 2021, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

Partnership Health Plan of California

N/A

San Francisco Health Plan

N/A

Santa Clara Family Health Plan

Yes. For rating period CY 2021, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

SCAN Health Plan

N/A

D1II.3

MLR reporting period discrepancies

Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?

Aetna Better Health of California

Yes

AIDS Healthcare Foundation

Yes

Alameda Alliance for Health

Yes

Anthem Blue Cross

Yes

Blue Shield of California Promise

Yes

California Health and Wellness Plan

Yes

CalOptima

Yes

CalViva Health

Yes

CenCal Health

Yes

Central California Alliance for Health

Yes

Community Health Group

Yes

Contra Costa Health Plan

Yes

Gold Coast Health Plan

Yes

Health Net Community Solutions

Yes

Health Plan of San Joaquin

Yes

Health Plan of San Mateo

Yes

Inland Empire Health Plan

Yes

Kaiser Permanente

Yes

Kern Health Systems

		Yes **L.A. Care Health Plan** Yes **Molina Healthcare of California** Yes **Partnership Health Plan of California** Yes **San Francisco Health Plan** Yes **Santa Clara Family Health Plan** Yes **SCAN Health Plan** Yes
N/A	Enter the start date.	**Aetna Better Health of California** 01/01/2021 **AIDS Healthcare Foundation** 01/01/2021 **Alameda Alliance for Health** 01/01/2021 **Anthem Blue Cross** 01/01/2021 **Blue Shield of California Promise** 01/01/2021 **California Health and Wellness Plan** 01/01/2021 **CalOptima**

01/01/2021

CalViva Health

01/01/2021

CenCal Health

01/01/2021

Central California Alliance for Health

01/01/2021

Community Health Group

01/01/2021

Contra Costa Health Plan

01/01/2021

Gold Coast Health Plan

01/01/2021

Health Net Community Solutions

01/01/2021

Health Plan of San Joaquin

01/01/2021

Health Plan of San Mateo

01/01/2021

Inland Empire Health Plan

01/01/2021

Kaiser Permanente

01/01/2021

Kern Health Systems

01/01/2021

L.A. Care Health Plan

		01/01/2021 **Molina Healthcare of California** 01/01/2021 **Partnership Health Plan of California** 01/01/2021 **San Francisco Health Plan** 01/01/2021 **Santa Clara Family Health Plan** 01/01/2021 **SCAN Health Plan** 01/01/2021
N/A	Enter the end date.	**Aetna Better Health of California** 12/31/2021 **AIDS Healthcare Foundation** 12/31/2021 **Alameda Alliance for Health** 12/31/2021 **Anthem Blue Cross** 12/31/2021 **Blue Shield of California Promise** 12/31/2021 **California Health and Wellness Plan** 12/31/2021 **CalOptima** 12/31/2021 **CalViva Health**

12/31/2021

CenCal Health

12/31/2021

Central California Alliance for Health

12/31/2021

Community Health Group

12/31/2021

Contra Costa Health Plan

12/31/2021

Gold Coast Health Plan

12/31/2021

Health Net Community Solutions

12/31/2021

Health Plan of San Joaquin

12/31/2021

Health Plan of San Mateo

12/31/2021

Inland Empire Health Plan

12/31/2021

Kaiser Permanente

12/31/2021

Kern Health Systems

12/31/2021

L.A. Care Health Plan

12/31/2021

Molina Healthcare of California

12/31/2021

Partnership Health Plan of California

12/31/2021

San Francisco Health Plan

12/31/2021

Santa Clara Family Health Plan

12/31/2021

SCAN Health Plan

12/31/2021

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Aetna Better Health of California** Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice. **AIDS Healthcare Foundation** Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice. **Alameda Alliance for Health** Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice. **Anthem Blue Cross** Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice. **Blue Shield of California Promise** Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the

format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

California Health and Wellness Plan

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

CalOptima

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

CalViva Health

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

CenCal Health

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Central California Alliance for Health

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Community Health Group

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Contra Costa Health Plan

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Gold Coast Health Plan

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Health Net Community Solutions

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Health Plan of San Joaquin

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Health Plan of San Mateo

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Inland Empire Health Plan

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Kaiser Permanente

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Kern Health Systems

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is

resubmitted within 15 calendar days of the date of DHCS' notice.

L.A. Care Health Plan

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Molina Healthcare of California

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Partnership Health Plan of California

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

San Francisco Health Plan

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.

Santa Clara Family Health Plan

Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as

		otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice. **SCAN Health Plan** Contractor shall submit within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**Aetna Better Health of California** 73.99% **AIDS Healthcare Foundation** 62.99% **Alameda Alliance for Health** 82.34% **Anthem Blue Cross** 80.29% **Blue Shield of California Promise** 65.93% **California Health and Wellness Plan** 78.85% **CalOptima** 71.42% **CalViva Health** 67.38% **CenCal Health**

86.85%

Central California Alliance for Health

85.75%

Community Health Group

83.13%

Contra Costa Health Plan

82.82%

Gold Coast Health Plan

85.46%

Health Net Community Solutions

64.19%

Health Plan of San Joaquin

80.23%

Health Plan of San Mateo

84.77%

Inland Empire Health Plan

55.62%

Kaiser Permanente

69.56%

Kern Health Systems

59.79%

L.A. Care Health Plan

68.55%

Molina Healthcare of California

81.21%

Partnership Health Plan of California

78.56%

San Francisco Health Plan

82.54%

Santa Clara Family Health Plan

76.19%

SCAN Health Plan

50.63%

D1III.3

Share of encounter data submissions that were HIPAA compliant

What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance?
If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.

Aetna Better Health of California

99.84%

AIDS Healthcare Foundation

99.9%

Alameda Alliance for Health

99.96%

Anthem Blue Cross

99.79%

Blue Shield of California Promise

99.93%

California Health and Wellness Plan

99.91%

CalOptima

99.88%

CalViva Health

99.92%

CenCal Health

99.99%

Central California Alliance for Health

99.99%

Community Health Group

99.73%

Contra Costa Health Plan

99.9%

Gold Coast Health Plan

99.9%

Health Net Community Solutions

99.32%

Health Plan of San Joaquin

99.97%

Health Plan of San Mateo

99.82%

Inland Empire Health Plan

99.95%

Kaiser Permanente

99.94%

Kern Health Systems

99.97%

L.A. Care Health Plan

100%

Molina Healthcare of California

99.8%

Partnership Health Plan of California

99.98%

San Francisco Health Plan

99.99%

Santa Clara Family Health Plan

99.87%

SCAN Health Plan

99.96%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Aetna Better Health of California** 923 **AIDS Healthcare Foundation** 0 **Alameda Alliance for Health** 348 **Anthem Blue Cross** 498 **Blue Shield of California Promise** 142 **California Health and Wellness Plan** 526 **CalOptima** 1,280 **CalViva Health** 360 **CenCal Health** 53 **Central California Alliance for Health** 177 **Community Health Group** 73 **Contra Costa Health Plan** 216 **Gold Coast Health Plan**

177

Health Net Community Solutions

1,085

Health Plan of San Joaquin

180

Health Plan of San Mateo

119

Inland Empire Health Plan

1,181

Kaiser Permanente

207

Kern Health Systems

1,700

L.A. Care Health Plan

1,986

Molina Healthcare of California

732

Partnership Health Plan of California

1,086

San Francisco Health Plan

88

Santa Clara Family Health Plan

202

SCAN Health Plan

2

D1IV.2	**Active appeals**	**Aetna Better Health of California**

Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.

0

AIDS Healthcare Foundation

0

Alameda Alliance for Health

12

Anthem Blue Cross

19

Blue Shield of California Promise

11

California Health and Wellness Plan

0

CalOptima

3

CalViva Health

0

CenCal Health

71

Central California Alliance for Health

0

Community Health Group

0

Contra Costa Health Plan

4

Gold Coast Health Plan

15

Health Net Community Solutions

0

Health Plan of San Joaquin

5

Health Plan of San Mateo

4

Inland Empire Health Plan

16

Kaiser Permanente

17

Kern Health Systems

16

L.A. Care Health Plan

65

Molina Healthcare of California

23

Partnership Health Plan of California

40

San Francisco Health Plan

34

Santa Clara Family Health Plan

159

SCAN Health Plan

0

D1IV.3

Appeals filed on behalf of LTSS users

Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not

Aetna Better Health of California

107

AIDS Healthcare Foundation

applicable.
An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).

0

Alameda Alliance for Health

5

Anthem Blue Cross

0

Blue Shield of California Promise

3

California Health and Wellness Plan

0

CalOptima

32

CalViva Health

0

CenCal Health

2

Central California Alliance for Health

5

Community Health Group

0

Contra Costa Health Plan

0

Gold Coast Health Plan

17

Health Net Community Solutions

8

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

19

Kaiser Permanente

0

Kern Health Systems

1

L.A. Care Health Plan

62

Molina Healthcare of California

10

Partnership Health Plan of California

20

San Francisco Health Plan

1

Santa Clara Family Health Plan

0

SCAN Health Plan

0

D1IV.4

Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who

Aetna Better Health of California

0

AIDS Healthcare Foundation

0

Alameda Alliance for Health

previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”.
Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”.
The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.
To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

0

Anthem Blue Cross

0

Blue Shield of California Promise

0

California Health and Wellness Plan

0

CalOptima

1

CalViva Health

1

CenCal Health

0

Central California Alliance for Health

0

Community Health Group

0

Contra Costa Health Plan

0

Gold Coast Health Plan

0

Health Net Community Solutions

7

Health Plan of San Joaquin

0

Health Plan of San Mateo

1

Inland Empire Health Plan

9

Kaiser Permanente

8

Kern Health Systems

0

L.A. Care Health Plan

1

Molina Healthcare of California

15

Partnership Health Plan of California

0

San Francisco Health Plan

0

Santa Clara Family Health Plan

0

SCAN Health Plan

5

D1IV.5a

Standard appeals for which timely resolution was provided

Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year.
See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.

Aetna Better Health of California

918

AIDS Healthcare Foundation

0

Alameda Alliance for Health

342

Anthem Blue Cross

467

Blue Shield of California Promise

137

California Health and Wellness Plan

497

CalOptima

1,188

CalViva Health

325

CenCal Health

53

Central California Alliance for Health

167

Community Health Group

71

Contra Costa Health Plan

176

Gold Coast Health Plan

164

Health Net Community Solutions

1,001

Health Plan of San Joaquin

165

Health Plan of San Mateo

111

Inland Empire Health Plan

1,099

Kaiser Permanente

175

Kern Health Systems

1,596

L.A. Care Health Plan

1,847

Molina Healthcare of California

692

Partnership Health Plan of California

1,079

San Francisco Health Plan

84

Santa Clara Family Health Plan

169

SCAN Health Plan

2

D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Aetna Better Health of California** 5 **AIDS Healthcare Foundation** 0 **Alameda Alliance for Health** 6 **Anthem Blue Cross** 31 **Blue Shield of California Promise**

5

California Health and Wellness Plan

29

CalOptima

92

CalViva Health

35

CenCal Health

0

Central California Alliance for Health

10

Community Health Group

2

Contra Costa Health Plan

40

Gold Coast Health Plan

13

Health Net Community Solutions

84

Health Plan of San Joaquin

15

Health Plan of San Mateo

8

Inland Empire Health Plan

82

Kaiser Permanente

32

Kern Health Systems

104

L.A. Care Health Plan

139

Molina Healthcare of California

40

Partnership Health Plan of California

7

San Francisco Health Plan

4

Santa Clara Family Health Plan

33

SCAN Health Plan

0

D1IV.6a

Resolved appeals related to denial of authorization or limited authorization of a service

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service.
(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).

Aetna Better Health of California

591

AIDS Healthcare Foundation

0

Alameda Alliance for Health

348

Anthem Blue Cross

498

Blue Shield of California Promise

92

California Health and Wellness Plan

526

CalOptima

1,211

CalViva Health

352

CenCal Health

53

Central California Alliance for Health

177

Community Health Group

73

Contra Costa Health Plan

215

Gold Coast Health Plan

174

Health Net Community Solutions

1,047

Health Plan of San Joaquin

13

Health Plan of San Mateo

119

Inland Empire Health Plan

1,181

Kaiser Permanente

206

Kern Health Systems

1,700

L.A. Care Health Plan

1,764

Molina Healthcare of California

473

Partnership Health Plan of California

1,058

San Francisco Health Plan

84

Santa Clara Family Health Plan

198

SCAN Health Plan

2

D1IV.6b

Resolved appeals related to reduction, suspension, or termination of a previously authorized service

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.

Aetna Better Health of California

0

AIDS Healthcare Foundation

0

Alameda Alliance for Health

0

Anthem Blue Cross

0

Blue Shield of California Promise

0

California Health and Wellness Plan

0

CalOptima

0

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

0

Community Health Group

0

Contra Costa Health Plan

0

Gold Coast Health Plan

1

Health Net Community Solutions

0

Health Plan of San Joaquin

7

Health Plan of San Mateo

0

Inland Empire Health Plan

0

Kaiser Permanente

0

Kern Health Systems

0

L.A. Care Health Plan

0

Molina Healthcare of California

0

Partnership Health Plan of California

0

San Francisco Health Plan

0

Santa Clara Family Health Plan

0

SCAN Health Plan

0

D1IV.6c

Resolved appeals related to payment denial

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.

Aetna Better Health of California

330

AIDS Healthcare Foundation

0

Alameda Alliance for Health

1

Anthem Blue Cross

0

Blue Shield of California Promise

50

California Health and Wellness Plan

0

CalOptima

4

CalViva Health

6

CenCal Health

0

Central California Alliance for Health

0

Community Health Group

0

Contra Costa Health Plan

6

Gold Coast Health Plan

0

Health Net Community Solutions

37

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

1

Kaiser Permanente

2

Kern Health Systems

0

L.A. Care Health Plan

66

Molina Healthcare of California

245

Partnership Health Plan of California

25

San Francisco Health Plan

4

Santa Clara Family Health Plan

3

SCAN Health Plan

0

D1IV.6d

Resolved appeals related to service timeliness

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).

Aetna Better Health of California

0

AIDS Healthcare Foundation

0

Alameda Alliance for Health

0

Anthem Blue Cross

0

Blue Shield of California Promise

0

California Health and Wellness Plan

0

CalOptima

68

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

0

Community Health Group

0

Contra Costa Health Plan

0

Gold Coast Health Plan

1

Health Net Community Solutions

0

Health Plan of San Joaquin

30

Health Plan of San Mateo

0

Inland Empire Health Plan

1

Kaiser Permanente

1

Kern Health Systems

0

L.A. Care Health Plan

153

Molina Healthcare of California

1

Partnership Health Plan of California

2

San Francisco Health Plan

0

Santa Clara Family Health Plan

1

SCAN Health Plan

0

D1IV.6e

Resolved appeals related to lack of timely plan response to an appeal or grievance

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

Aetna Better Health of California

0

AIDS Healthcare Foundation

0

Alameda Alliance for Health

2

Anthem Blue Cross

0

Blue Shield of California Promise

0

California Health and Wellness Plan

0

CalOptima

1

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

0

Community Health Group

0

Contra Costa Health Plan

0

Gold Coast Health Plan

2

Health Net Community Solutions

0

Health Plan of San Joaquin

166

Health Plan of San Mateo

1

Inland Empire Health Plan

3

Kaiser Permanente

10

Kern Health Systems

3

L.A. Care Health Plan

2

Molina Healthcare of California

4

Partnership Health Plan of California

2

San Francisco Health Plan

1

Santa Clara Family Health Plan

1

SCAN Health Plan

0

D1IV.6f

Resolved appeals related to plan denial of an enrollee's right to request out-of-network care

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).

Aetna Better Health of California

N/A

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

N/A

Anthem Blue Cross

N/A

Blue Shield of California Promise

N/A

California Health and Wellness Plan

N/A

CalOptima

N/A

CalViva Health

N/A

CenCal Health

N/A

Central California Alliance for Health

N/A

Community Health Group

N/A

Contra Costa Health Plan

N/A

Gold Coast Health Plan

N/A

Health Net Community Solutions

N/A

Health Plan of San Joaquin

N/A

Health Plan of San Mateo

N/A

Inland Empire Health Plan

N/A

Kaiser Permanente

N/A

Kern Health Systems

N/A

L.A. Care Health Plan

N/A

Molina Healthcare of California

N/A

Partnership Health Plan of California

2

San Francisco Health Plan

N/A

Santa Clara Family Health Plan

N/A

SCAN Health Plan

N/A

D1IV.6g

Resolved appeals related to denial of an enrollee's request to dispute financial liability

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.

Aetna Better Health of California

2

AIDS Healthcare Foundation

0

Alameda Alliance for Health

0

Anthem Blue Cross

0

Blue Shield of California Promise

0

California Health and Wellness Plan

0

CalOptima

2

CalViva Health

2

CenCal Health

0

Central California Alliance for Health

0

Community Health Group

0

Contra Costa Health Plan

0

Gold Coast Health Plan

0

Health Net Community Solutions

1

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

0

Kaiser Permanente

0

Kern Health Systems

0

L.A. Care Health Plan

7

Molina Healthcare of California

9

Partnership Health Plan of California

1

San Francisco Health Plan

0

Santa Clara Family Health Plan

0

SCAN Health Plan

0

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Aetna Better Health of California** 103 **AIDS Healthcare Foundation** 0 **Alameda Alliance for Health** 10 **Anthem Blue Cross** 34 **Blue Shield of California Promise** 9 **California Health and Wellness Plan** 16 **CalOptima** 35 **CalViva Health** 5 **CenCal Health** 1 **Central California Alliance for Health** 9 **Community Health Group** 2 **Contra Costa Health Plan** 17 **Gold Coast Health Plan**

28

Health Net Community Solutions

40

Health Plan of San Joaquin

0

Health Plan of San Mateo

3

Inland Empire Health Plan

1

Kaiser Permanente

0

Kern Health Systems

12

L.A. Care Health Plan

102

Molina Healthcare of California

57

Partnership Health Plan of California

223

San Francisco Health Plan

4

Santa Clara Family Health Plan

9

SCAN Health Plan

0

D1IV.7b

Resolved appeals related to general outpatient services

Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".

Aetna Better Health of California

658

AIDS Healthcare Foundation

0

Alameda Alliance for Health

256

Anthem Blue Cross

350

Blue Shield of California Promise

83

California Health and Wellness Plan

444

CalOptima

887

CalViva Health

306

CenCal Health

33

Central California Alliance for Health

84

Community Health Group

9

Contra Costa Health Plan

106

Gold Coast Health Plan

89

		Health Net Community Solutions 823 **Health Plan of San Joaquin** 116 **Health Plan of San Mateo** 57 **Inland Empire Health Plan** 420 **Kaiser Permanente** 0 **Kern Health Systems** 1,528 **L.A. Care Health Plan** 295 **Molina Healthcare of California** 328 **Partnership Health Plan of California** 362 **San Francisco Health Plan** 35 **Santa Clara Family Health Plan** 144 **SCAN Health Plan** 0
D1IV.7c	**Resolved appeals related to inpatient behavioral health services**	**Aetna Better Health of California** N/A

Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

N/A

Anthem Blue Cross

N/A

Blue Shield of California Promise

N/A

California Health and Wellness Plan

N/A

CalOptima

N/A

CalViva Health

N/A

CenCal Health

N/A

Central California Alliance for Health

N/A

Community Health Group

N/A

Contra Costa Health Plan

N/A

Gold Coast Health Plan

N/A

Health Net Community Solutions

N/A

Health Plan of San Joaquin

N/A

Health Plan of San Mateo

N/A

Inland Empire Health Plan

N/A

Kaiser Permanente

N/A

Kern Health Systems

N/A

L.A. Care Health Plan

N/A

Molina Healthcare of California

N/A

Partnership Health Plan of California

N/A

San Francisco Health Plan

N/A

Santa Clara Family Health Plan

N/A

SCAN Health Plan

N/A

D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the	**Aetna Better Health of California** 8 **AIDS Healthcare Foundation** 0

managed care plan does not cover outpatient behavioral health services, enter "N/A".

Alameda Alliance for Health

4

Anthem Blue Cross

0

Blue Shield of California Promise

4

California Health and Wellness Plan

5

CalOptima

4

CalViva Health

1

CenCal Health

3

Central California Alliance for Health

3

Community Health Group

0

Contra Costa Health Plan

5

Gold Coast Health Plan

6

Health Net Community Solutions

22

Health Plan of San Joaquin

0

Health Plan of San Mateo

5

Inland Empire Health Plan

68

Kaiser Permanente

5

Kern Health Systems

4

L.A. Care Health Plan

30

Molina Healthcare of California

10

Partnership Health Plan of California

3

San Francisco Health Plan

0

Santa Clara Family Health Plan

1

SCAN Health Plan

0

D1IV.7e

Resolved appeals related to covered outpatient prescription drugs

Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".

Aetna Better Health of California

0

AIDS Healthcare Foundation

0

Alameda Alliance for Health

6

Anthem Blue Cross

20

Blue Shield of California Promise

1

California Health and Wellness Plan

2

CalOptima

11

CalViva Health

2

CenCal Health

2

Central California Alliance for Health

15

Community Health Group

0

Contra Costa Health Plan

5

Gold Coast Health Plan

1

Health Net Community Solutions

2

Health Plan of San Joaquin

1

Health Plan of San Mateo

1

Inland Empire Health Plan

30

Kaiser Permanente

0

Kern Health Systems

11

L.A. Care Health Plan

12

Molina Healthcare of California

24

Partnership Health Plan of California

10

San Francisco Health Plan

8

Santa Clara Family Health Plan

0

SCAN Health Plan

0

D1IV.7f

Resolved appeals related to skilled nursing facility (SNF) services

Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".

Aetna Better Health of California

62

AIDS Healthcare Foundation

0

Alameda Alliance for Health

5

Anthem Blue Cross

0

Blue Shield of California Promise

3

California Health and Wellness Plan

0

CalOptima

24

CalViva Health

0

CenCal Health

1

Central California Alliance for Health

3

Community Health Group

0

Contra Costa Health Plan

0

Gold Coast Health Plan

15

Health Net Community Solutions

8

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

19

Kaiser Permanente

0

Kern Health Systems

1

L.A. Care Health Plan

49

Molina Healthcare of California

2

Partnership Health Plan of California

20

San Francisco Health Plan

0

Santa Clara Family Health Plan

0

SCAN Health Plan

0

D1IV.7g

Resolved appeals related to long-term services and supports (LTSS)

Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".

Aetna Better Health of California

45

AIDS Healthcare Foundation

0

Alameda Alliance for Health

0

Anthem Blue Cross

0

Blue Shield of California Promise

0

California Health and Wellness Plan

0

CalOptima

8

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

2

Community Health Group

0

Contra Costa Health Plan

0

Gold Coast Health Plan

1

Health Net Community Solutions

0

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

0

Kaiser Permanente

0

Kern Health Systems

0

L.A. Care Health Plan

13

Molina Healthcare of California

8

Partnership Health Plan of California

0

San Francisco Health Plan

1

Santa Clara Family Health Plan

0

SCAN Health Plan

0

D1IV.7h

Resolved appeals related to dental services

Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".

Aetna Better Health of California

N/A

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

N/A

Anthem Blue Cross

N/A

Blue Shield of California Promise

N/A

California Health and Wellness Plan

N/A

CalOptima

N/A

CalViva Health

N/A

CenCal Health

N/A

Central California Alliance for Health

N/A

Community Health Group

N/A

Contra Costa Health Plan

N/A

Gold Coast Health Plan

N/A

Health Net Community Solutions

N/A

Health Plan of San Joaquin

N/A

Health Plan of San Mateo

11

Inland Empire Health Plan

N/A

Kaiser Permanente

N/A

Kern Health Systems

N/A

L.A. Care Health Plan

N/A

Molina Healthcare of California

N/A

Partnership Health Plan of California

N/A

San Francisco Health Plan

N/A

Santa Clara Family Health Plan

N/A

SCAN Health Plan

N/A

D1IV.7i

Resolved appeals related to non-emergency medical transportation (NEMT)

Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".

Aetna Better Health of California

7

AIDS Healthcare Foundation

0

Alameda Alliance for Health

4

Anthem Blue Cross

0

Blue Shield of California Promise

0

California Health and Wellness Plan

1

CalOptima

3

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

0

Community Health Group

0

Contra Costa Health Plan

3

Gold Coast Health Plan

0

Health Net Community Solutions

6

Health Plan of San Joaquin

1

Health Plan of San Mateo

1

Inland Empire Health Plan

13

Kaiser Permanente

19

Kern Health Systems

0

L.A. Care Health Plan

17

Molina Healthcare of California

0

Partnership Health Plan of California

9

San Francisco Health Plan

3

Santa Clara Family Health Plan

7

SCAN Health Plan

0

D1IV.7j

Resolved appeals related to other service types

Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i paid primarily by Medicaid, enter "N/A".

Aetna Better Health of California

40

AIDS Healthcare Foundation

0

Alameda Alliance for Health

63

Anthem Blue Cross

94

Blue Shield of California Promise

42

California Health and Wellness Plan

58

CalOptima

308

CalViva Health

46

CenCal Health

13

Central California Alliance for Health

61

Community Health Group

62

Contra Costa Health Plan

80

Gold Coast Health Plan

37

Health Net Community Solutions

184

Health Plan of San Joaquin

62

Health Plan of San Mateo

41

Inland Empire Health Plan

630

Kaiser Permanente

183

Kern Health Systems

144

L.A. Care Health Plan

1,468

Molina Healthcare of California

303

Partnership Health Plan of California

459

San Francisco Health Plan

37

Santa Clara Family Health Plan

41

SCAN Health Plan

2

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Aetna Better Health of California** 22 **AIDS Healthcare Foundation** 0 **Alameda Alliance for Health** 53 **Anthem Blue Cross** 251 **Blue Shield of California Promise** 18 **California Health and Wellness Plan** 48 **CalOptima** 134 **CalViva Health** 41 **CenCal Health** 15 **Central California Alliance for Health** 25 **Community Health Group** 31 **Contra Costa Health Plan** 65 **Gold Coast Health Plan**

27

Health Net Community Solutions

292

Health Plan of San Joaquin

78

Health Plan of San Mateo

10

Inland Empire Health Plan

118

Kaiser Permanente

38

Kern Health Systems

50

L.A. Care Health Plan

434

Molina Healthcare of California

59

Partnership Health Plan of California

121

San Francisco Health Plan

21

Santa Clara Family Health Plan

46

SCAN Health Plan

1

D1IV.8b

State Fair Hearings resulting in a favorable decision for the enrollee

Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.

Aetna Better Health of California

2

AIDS Healthcare Foundation

0

Alameda Alliance for Health

3

Anthem Blue Cross

19

Blue Shield of California Promise

2

California Health and Wellness Plan

4

CalOptima

2

CalViva Health

0

CenCal Health

1

Central California Alliance for Health

0

Community Health Group

4

Contra Costa Health Plan

4

Gold Coast Health Plan

3

		Health Net Community Solutions 15 **Health Plan of San Joaquin** 2 **Health Plan of San Mateo** 0 **Inland Empire Health Plan** 4 **Kaiser Permanente** 3 **Kern Health Systems** 3 **L.A. Care Health Plan** 34 **Molina Healthcare of California** 6 **Partnership Health Plan of California** 9 **San Francisco Health Plan** 0 **Santa Clara Family Health Plan** 3 **SCAN Health Plan** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee**	**Aetna Better Health of California** 15

Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.

AIDS Healthcare Foundation

0

Alameda Alliance for Health

40

Anthem Blue Cross

139

Blue Shield of California Promise

8

California Health and Wellness Plan

21

CalOptima

58

CalViva Health

11

CenCal Health

7

Central California Alliance for Health

7

Community Health Group

20

Contra Costa Health Plan

36

Gold Coast Health Plan

9

Health Net Community Solutions

179

Health Plan of San Joaquin

24

Health Plan of San Mateo

6

Inland Empire Health Plan

79

Kaiser Permanente

25

Kern Health Systems

15

L.A. Care Health Plan

257

Molina Healthcare of California

28

Partnership Health Plan of California

52

San Francisco Health Plan

14

Santa Clara Family Health Plan

24

SCAN Health Plan

0

D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the	**Aetna Better Health of California** 5 **AIDS Healthcare Foundation** 0

reporting year prior to reaching a decision.

Alameda Alliance for Health

10

Anthem Blue Cross

93

Blue Shield of California Promise

8

California Health and Wellness Plan

23

CalOptima

74

CalViva Health

30

CenCal Health

7

Central California Alliance for Health

18

Community Health Group

7

Contra Costa Health Plan

25

Gold Coast Health Plan

15

Health Net Community Solutions

98

Health Plan of San Joaquin

52

Health Plan of San Mateo

4

Inland Empire Health Plan

35

Kaiser Permanente

10

Kern Health Systems

32

L.A. Care Health Plan

143

Molina Healthcare of California

25

Partnership Health Plan of California

60

San Francisco Health Plan

7

Santa Clara Family Health Plan

19

SCAN Health Plan

1

D1IV.9a

External Medical Reviews resulting in a favorable decision for the enrollee

If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A".

Aetna Better Health of California

0

AIDS Healthcare Foundation

0

Alameda Alliance for Health

3

External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

Anthem Blue Cross

9

Blue Shield of California Promise

2

California Health and Wellness Plan

5

CalOptima

0

CalViva Health

1

CenCal Health

0

Central California Alliance for Health

0

Community Health Group

1

Contra Costa Health Plan

3

Gold Coast Health Plan

0

Health Net Community Solutions

8

Health Plan of San Joaquin

3

Health Plan of San Mateo

0

Inland Empire Health Plan

5

Kaiser Permanente

5

Kern Health Systems

10

L.A. Care Health Plan

14

Molina Healthcare of California

5

Partnership Health Plan of California

0

San Francisco Health Plan

0

Santa Clara Family Health Plan

4

SCAN Health Plan

0

D1IV.9b

External Medical Reviews resulting in an adverse decision for the enrollee

If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A".
External medical review is defined and described at 42

Aetna Better Health of California

0

AIDS Healthcare Foundation

0

Alameda Alliance for Health

6

Anthem Blue Cross

8

CFR §438.402(c)(i)(B).

Blue Shield of California Promise

4

California Health and Wellness Plan

0

CalOptima

0

CalViva Health

2

CenCal Health

0

Central California Alliance for Health

0

Community Health Group

5

Contra Costa Health Plan

3

Gold Coast Health Plan

0

Health Net Community Solutions

10

Health Plan of San Joaquin

2

Health Plan of San Mateo

6

Inland Empire Health Plan

14

Kaiser Permanente

8

Kern Health Systems

6

L.A. Care Health Plan

20

Molina Healthcare of California

3

Partnership Health Plan of California

0

San Francisco Health Plan

2

Santa Clara Family Health Plan

5

SCAN Health Plan

0

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Aetna Better Health of California** 855 **AIDS Healthcare Foundation** 91 **Alameda Alliance for Health** 30,368 **Anthem Blue Cross** 13,944 **Blue Shield of California Promise** 3,931 **California Health and Wellness Plan** 3,686 **CalOptima** 19,515 **CalViva Health** 3,836 **CenCal Health** 1,048 **Central California Alliance for Health** 4,750 **Community Health Group** 1,120 **Contra Costa Health Plan** 3,394 **Gold Coast Health Plan**

1,133

Health Net Community Solutions

17,799

Health Plan of San Joaquin

4,580

Health Plan of San Mateo

1,403

Inland Empire Health Plan

178,128

Kaiser Permanente

12,863

Kern Health Systems

13,428

L.A. Care Health Plan

52,018

Molina Healthcare of California

13,098

Partnership Health Plan of California

8,727

San Francisco Health Plan

1,661

Santa Clara Family Health Plan

4,710

SCAN Health Plan

220

D1IV.11	**Active grievances**	**Aetna Better Health of California**

Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.

4

AIDS Healthcare Foundation

4

Alameda Alliance for Health

185

Anthem Blue Cross

41

Blue Shield of California Promise

7

California Health and Wellness Plan

0

CalOptima

104

CalViva Health

0

CenCal Health

268

Central California Alliance for Health

39

Community Health Group

11

Contra Costa Health Plan

147

Gold Coast Health Plan

223

Health Net Community Solutions

0

Health Plan of San Joaquin

35

Health Plan of San Mateo

90

Inland Empire Health Plan

1,563

Kaiser Permanente

788

Kern Health Systems

139

L.A. Care Health Plan

5,596

Molina Healthcare of California

688

Partnership Health Plan of California

241

San Francisco Health Plan

501

Santa Clara Family Health Plan

834

SCAN Health Plan

41

D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the	**Aetna Better Health of California** 3 **AIDS Healthcare Foundation**

reporting year by or on behalf of LTSS users.
An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.

2

Alameda Alliance for Health

71

Anthem Blue Cross

0

Blue Shield of California Promise

41

California Health and Wellness Plan

0

CalOptima

74

CalViva Health

0

CenCal Health

2

Central California Alliance for Health

97

Community Health Group

56

Contra Costa Health Plan

10

Gold Coast Health Plan

15

Health Net Community Solutions

4

Health Plan of San Joaquin

26

Health Plan of San Mateo

8

Inland Empire Health Plan

323

Kaiser Permanente

0

Kern Health Systems

37

L.A. Care Health Plan

436

Molina Healthcare of California

40

Partnership Health Plan of California

18

San Francisco Health Plan

6

Santa Clara Family Health Plan

2

SCAN Health Plan

0

D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on	**Aetna Better Health of California** 0 **AIDS Healthcare Foundation** 0 **Alameda Alliance for Health**

behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.
If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field.
To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

0

Anthem Blue Cross

0

Blue Shield of California Promise

0

California Health and Wellness Plan

2

CalOptima

2

CalViva Health

13

CenCal Health

0

Central California Alliance for Health

7

Community Health Group

4

Contra Costa Health Plan

1

Gold Coast Health Plan

0

Health Net Community Solutions

133

Health Plan of San Joaquin

0

Health Plan of San Mateo

4

Inland Empire Health Plan

88

Kaiser Permanente

147

Kern Health Systems

5

L.A. Care Health Plan

61

Molina Healthcare of California

72

Partnership Health Plan of California

0

San Francisco Health Plan

0

Santa Clara Family Health Plan

0

SCAN Health Plan

15

D1IV.14

Number of grievances for which timely resolution was provided

Enter the number of grievances for which timely resolution was provided by plan during the reporting year.
See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.

Aetna Better Health of California

847

AIDS Healthcare Foundation

90

Alameda Alliance for Health

30,108

Anthem Blue Cross

13,765

Blue Shield of California Promise

3,922

California Health and Wellness Plan

3,685

CalOptima

19,444

CalViva Health

3,834

CenCal Health

1,048

Central California Alliance for Health

4,732

Community Health Group

1,120

Contra Costa Health Plan

3,264

Gold Coast Health Plan

1,026

Health Net Community Solutions

17,759

Health Plan of San Joaquin

4,530

Health Plan of San Mateo

1,377

Inland Empire Health Plan

176,960

Kaiser Permanente

12,432

Kern Health Systems

12,951

L.A. Care Health Plan

51,335

Molina Healthcare of California

13,075

Partnership Health Plan of California

8,573

San Francisco Health Plan

1,601

Santa Clara Family Health Plan

4,573

SCAN Health Plan

220

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health of California** 5 **AIDS Healthcare Foundation** 0 **Alameda Alliance for Health** 87 **Anthem Blue Cross** 3 **Blue Shield of California Promise** 47 **California Health and Wellness Plan** 21 **CalOptima** 149 **CalViva Health** 23 **CenCal Health** 9 **Central California Alliance for Health** 137 **Community Health Group** 15 **Contra Costa Health Plan** 22 **Gold Coast Health Plan**

12

Health Net Community Solutions

163

Health Plan of San Joaquin

37

Health Plan of San Mateo

11

Inland Empire Health Plan

557

Kaiser Permanente

63

Kern Health Systems

18

L.A. Care Health Plan

2,490

Molina Healthcare of California

52

Partnership Health Plan of California

59

San Francisco Health Plan

10

Santa Clara Family Health Plan

26

SCAN Health Plan

0

D1IV.15b

Resolved grievances related to general outpatient services

Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of California

586

AIDS Healthcare Foundation

31

Alameda Alliance for Health

13,608

Anthem Blue Cross

40

Blue Shield of California Promise

2,339

California Health and Wellness Plan

1,775

CalOptima

9,656

CalViva Health

2,090

CenCal Health

954

Central California Alliance for Health

2,134

Community Health Group

652

Contra Costa Health Plan

347

Gold Coast Health Plan

454

		Health Net Community Solutions 7,585 **Health Plan of San Joaquin** 2,184 **Health Plan of San Mateo** 417 **Inland Empire Health Plan** 30,129 **Kaiser Permanente** 0 **Kern Health Systems** 10,698 **L.A. Care Health Plan** 7,384 **Molina Healthcare of California** 922 **Partnership Health Plan of California** 1,669 **San Francisco Health Plan** 283 **Santa Clara Family Health Plan** 2,081 **SCAN Health Plan** 1
D1IV.15c	**Resolved grievances related to inpatient behavioral health services**	**Aetna Better Health of California** N/A

Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

N/A

Anthem Blue Cross

N/A

Blue Shield of California Promise

N/A

California Health and Wellness Plan

N/A

CalOptima

N/A

CalViva Health

N/A

CenCal Health

N/A

Central California Alliance for Health

N/A

Community Health Group

N/A

Contra Costa Health Plan

N/A

Gold Coast Health Plan

N/A

Health Net Community Solutions

N/A

Health Plan of San Joaquin

N/A

Health Plan of San Mateo

N/A

Inland Empire Health Plan

N/A

Kaiser Permanente

N/A

Kern Health Systems

N/A

L.A. Care Health Plan

N/A

Molina Healthcare of California

N/A

Partnership Health Plan of California

N/A

San Francisco Health Plan

N/A

Santa Clara Family Health Plan

N/A

SCAN Health Plan

N/A

D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the	**Aetna Better Health of California** 14 **AIDS Healthcare Foundation** 0

managed care plan does not cover this type of service, enter "N/A".

Alameda Alliance for Health

1,379

Anthem Blue Cross

1

Blue Shield of California Promise

165

California Health and Wellness Plan

8

CalOptima

598

CalViva Health

13

CenCal Health

26

Central California Alliance for Health

192

Community Health Group

28

Contra Costa Health Plan

208

Gold Coast Health Plan

112

Health Net Community Solutions

165

Health Plan of San Joaquin

106

Health Plan of San Mateo

89

Inland Empire Health Plan

1,241

Kaiser Permanente

967

Kern Health Systems

152

L.A. Care Health Plan

887

Molina Healthcare of California

148

Partnership Health Plan of California

490

San Francisco Health Plan

151

Santa Clara Family Health Plan

166

SCAN Health Plan

0

D1IV.15e

Resolved grievances related to coverage of outpatient prescription drugs

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of California

1

AIDS Healthcare Foundation

2

Alameda Alliance for Health

547

Anthem Blue Cross

0

Blue Shield of California Promise

51

California Health and Wellness Plan

24

CalOptima

253

CalViva Health

82

CenCal Health

2

Central California Alliance for Health

170

Community Health Group

0

Contra Costa Health Plan

252

Gold Coast Health Plan

47

Health Net Community Solutions

341

Health Plan of San Joaquin

75

Health Plan of San Mateo

47

Inland Empire Health Plan

1,182

Kaiser Permanente

1,048

Kern Health Systems

99

L.A. Care Health Plan

1,308

Molina Healthcare of California

155

Partnership Health Plan of California

358

San Francisco Health Plan

129

Santa Clara Family Health Plan

145

SCAN Health Plan

0

D1IV.15f

Resolved grievances related to skilled nursing facility (SNF) services

Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of California

3

AIDS Healthcare Foundation

2

Alameda Alliance for Health

66

Anthem Blue Cross

0

Blue Shield of California Promise

40

California Health and Wellness Plan

0

CalOptima

59

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

25

Community Health Group

55

Contra Costa Health Plan

9

Gold Coast Health Plan

12

Health Net Community Solutions

4

Health Plan of San Joaquin

26

Health Plan of San Mateo

5

Inland Empire Health Plan

303

Kaiser Permanente

0

Kern Health Systems

33

L.A. Care Health Plan

373

Molina Healthcare of California

37

Partnership Health Plan of California

18

San Francisco Health Plan

5

Santa Clara Family Health Plan

0

SCAN Health Plan

0

D1IV.15g

Resolved grievances related to long-term services and supports (LTSS)

Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of California

0

AIDS Healthcare Foundation

0

Alameda Alliance for Health

3

Anthem Blue Cross

0

Blue Shield of California Promise

1

California Health and Wellness Plan

0

CalOptima

15

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

72

Community Health Group

0

Contra Costa Health Plan

1

Gold Coast Health Plan

2

Health Net Community Solutions

0

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

3

Kaiser Permanente

0

Kern Health Systems

4

L.A. Care Health Plan

40

Molina Healthcare of California

3

Partnership Health Plan of California

0

San Francisco Health Plan

0

Santa Clara Family Health Plan

2

SCAN Health Plan

0

D1IV.15h

Resolved grievances related to dental services

Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of California

N/A

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

N/A

Anthem Blue Cross

N/A

Blue Shield of California Promise

N/A

California Health and Wellness Plan

N/A

CalOptima

N/A

CalViva Health

N/A

CenCal Health

N/A

Central California Alliance for Health

N/A

Community Health Group

N/A

Contra Costa Health Plan

N/A

Gold Coast Health Plan

N/A

Health Net Community Solutions

N/A

Health Plan of San Joaquin

N/A

Health Plan of San Mateo

187

Inland Empire Health Plan

N/A

Kaiser Permanente

N/A

Kern Health Systems

N/A

L.A. Care Health Plan

N/A

Molina Healthcare of California

N/A

Partnership Health Plan of California

N/A

San Francisco Health Plan

N/A

Santa Clara Family Health Plan

N/A

SCAN Health Plan

N/A

D1IV.15i

Resolved grievances related to non-emergency medical transportation (NEMT)

Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of California

19

AIDS Healthcare Foundation

13

Alameda Alliance for Health

292

Anthem Blue Cross

0

Blue Shield of California Promise

27

California Health and Wellness Plan

387

CalOptima

442

CalViva Health

392

CenCal Health

11

Central California Alliance for Health

85

Community Health Group

23

Contra Costa Health Plan

31

Gold Coast Health Plan

93

Health Net Community Solutions

2,537

Health Plan of San Joaquin

84

Health Plan of San Mateo

13

Inland Empire Health Plan

3,057

Kaiser Permanente

56

Kern Health Systems

229

L.A. Care Health Plan

1,348

Molina Healthcare of California

804

Partnership Health Plan of California

97

San Francisco Health Plan

4

Santa Clara Family Health Plan

4

SCAN Health Plan

0

D1IV.15j

Resolved grievances related to other service types

Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i paid primarily by Medicaid, enter "N/A".

Aetna Better Health of California

226

AIDS Healthcare Foundation

43

Alameda Alliance for Health

14,386

Anthem Blue Cross

13,900

Blue Shield of California Promise

1,261

California Health and Wellness Plan

1,471

CalOptima

8,338

CalViva Health

1,234

CenCal Health

46

Central California Alliance for Health

1,808

Community Health Group

347

Contra Costa Health Plan

2,521

Gold Coast Health Plan

401

Health Net Community Solutions

6,990

Health Plan of San Joaquin

2,068

Health Plan of San Mateo

634

Inland Empire Health Plan

141,656

Kaiser Permanente

10,719

Kern Health Systems

2,192

L.A. Care Health Plan

38,153

Molina Healthcare of California

10,917

Partnership Health Plan of California

6,027

San Francisco Health Plan

1,069

Santa Clara Family Health Plan

2,286

SCAN Health Plan

219

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Aetna Better Health of California** 161 **AIDS Healthcare Foundation** 31 **Alameda Alliance for Health** 7,277 **Anthem Blue Cross** 1,378 **Blue Shield of California Promise** 539 **California Health and Wellness Plan** 1,013 **CalOptima** 3,342 **CalViva Health** 1,203 **CenCal Health** 390 **Central California Alliance for Health** 1,214 **Community Health Group** 607 **Contra Costa Health Plan** 928 **Gold Coast Health Plan**

111

Health Net Community Solutions

4,946

Health Plan of San Joaquin

940

Health Plan of San Mateo

421

Inland Empire Health Plan

64,771

Kaiser Permanente

2,170

Kern Health Systems

4,706

L.A. Care Health Plan

9,488

Molina Healthcare of California

1,889

Partnership Health Plan of California

2,037

San Francisco Health Plan

338

Santa Clara Family Health Plan

746

SCAN Health Plan

21

D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Aetna Better Health of California** 3 **AIDS Healthcare Foundation** 0 **Alameda Alliance for Health** 2,057 **Anthem Blue Cross** 70 **Blue Shield of California Promise** 83 **California Health and Wellness Plan** 8 **CalOptima** 1,431 **CalViva Health** 1 **CenCal Health** 0 **Central California Alliance for Health** 34 **Community Health Group** 8 **Contra Costa Health Plan** 1,558 **Gold Coast Health Plan** 210

		Health Net Community Solutions 27 **Health Plan of San Joaquin** 480 **Health Plan of San Mateo** 260 **Inland Empire Health Plan** 6,423 **Kaiser Permanente** 7,778 **Kern Health Systems** 441 **L.A. Care Health Plan** 7,803 **Molina Healthcare of California** 3 **Partnership Health Plan of California** 2,649 **San Francisco Health Plan** 661 **Santa Clara Family Health Plan** 923 **SCAN Health Plan** 2
D1IV.16c	**Resolved grievances related to access to care/services from plan or provider**	**Aetna Better Health of California** 121

Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.

AIDS Healthcare Foundation

14

Alameda Alliance for Health

5,803

Anthem Blue Cross

2,467

Blue Shield of California Promise

565

California Health and Wellness Plan

542

CalOptima

3,487

CalViva Health

610

CenCal Health

514

Central California Alliance for Health

1,347

Community Health Group

51

Contra Costa Health Plan

531

Gold Coast Health Plan

235

Health Net Community Solutions

3,320

Health Plan of San Joaquin

1,551

Health Plan of San Mateo

187

Inland Empire Health Plan

60,053

Kaiser Permanente

1,597

Kern Health Systems

3,293

L.A. Care Health Plan

13,726

Molina Healthcare of California

2,448

Partnership Health Plan of California

1,450

San Francisco Health Plan

237

Santa Clara Family Health Plan

881

SCAN Health Plan

28

D1IV.16d

Resolved grievances related to quality of care

Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the

Aetna Better Health of California

19

AIDS Healthcare Foundation

6

effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.

Alameda Alliance for Health

780

Anthem Blue Cross

2,574

Blue Shield of California Promise

189

California Health and Wellness Plan

110

CalOptima

1,319

CalViva Health

250

CenCal Health

65

Central California Alliance for Health

770

Community Health Group

240

Contra Costa Health Plan

412

Gold Coast Health Plan

269

Health Net Community Solutions

1,242

Health Plan of San Joaquin

1,541

Health Plan of San Mateo

103

Inland Empire Health Plan

8,864

Kaiser Permanente

657

Kern Health Systems

2,667

L.A. Care Health Plan

2,623

Molina Healthcare of California

382

Partnership Health Plan of California

304

San Francisco Health Plan

50

Santa Clara Family Health Plan

92

SCAN Health Plan

0

D1IV.16e

Resolved grievances related to plan communications

Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications.
Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan

Aetna Better Health of California

40

AIDS Healthcare Foundation

1

Alameda Alliance for Health

5,371

communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.

Anthem Blue Cross

369

Blue Shield of California Promise

48

California Health and Wellness Plan

534

CalOptima

391

CalViva Health

259

CenCal Health

0

Central California Alliance for Health

221

Community Health Group

3

Contra Costa Health Plan

255

Gold Coast Health Plan

28

Health Net Community Solutions

651

Health Plan of San Joaquin

558

Health Plan of San Mateo

46

Inland Empire Health Plan

10,106

Kaiser Permanente

936

Kern Health Systems

262

L.A. Care Health Plan

3,794

Molina Healthcare of California

1,164

Partnership Health Plan of California

431

San Francisco Health Plan

138

Santa Clara Family Health Plan

187

SCAN Health Plan

3

D1IV.16f

Resolved grievances related to payment or billing issues

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.

Aetna Better Health of California

312

AIDS Healthcare Foundation

2

Alameda Alliance for Health

3,627

Anthem Blue Cross

7,172

Blue Shield of California Promise

777

California Health and Wellness Plan

679

CalOptima

3,128

CalViva Health

510

CenCal Health

9

Central California Alliance for Health

416

Community Health Group

8

Contra Costa Health Plan

10

Gold Coast Health Plan

20

Health Net Community Solutions

1,503

Health Plan of San Joaquin

45

Health Plan of San Mateo

51

Inland Empire Health Plan

14

Kaiser Permanente

17

Kern Health Systems

45

L.A. Care Health Plan

10,887

Molina Healthcare of California

1,432

Partnership Health Plan of California

46

San Francisco Health Plan

24

Santa Clara Family Health Plan

277

SCAN Health Plan

1

D1IV.16g

Resolved grievances related to suspected fraud

Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud.
Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.

Aetna Better Health of California

1

AIDS Healthcare Foundation

0

Alameda Alliance for Health

63

Anthem Blue Cross

44

Blue Shield of California Promise

13

California Health and Wellness Plan

1

CalOptima

29

CalViva Health

2

CenCal Health

0

Central California Alliance for Health

10

Community Health Group

2

Contra Costa Health Plan

11

Gold Coast Health Plan

3

Health Net Community Solutions

19

Health Plan of San Joaquin

4

Health Plan of San Mateo

6

Inland Empire Health Plan

38

Kaiser Permanente

54

		Kern Health Systems 74 **L.A. Care Health Plan** 197 **Molina Healthcare of California** 42 **Partnership Health Plan of California** 27 **San Francisco Health Plan** 7 **Santa Clara Family Health Plan** 11 **SCAN Health Plan** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Aetna Better Health of California** 0 **AIDS Healthcare Foundation** 1 **Alameda Alliance for Health** 23 **Anthem Blue Cross** 41 **Blue Shield of California Promise** 68 **California Health and Wellness Plan** 8

CalOptima

19

CalViva Health

22

CenCal Health

0

Central California Alliance for Health

7

Community Health Group

2

Contra Costa Health Plan

14

Gold Coast Health Plan

7

Health Net Community Solutions

100

Health Plan of San Joaquin

4

Health Plan of San Mateo

3

Inland Empire Health Plan

70

Kaiser Permanente

28

Kern Health Systems

62

L.A. Care Health Plan

135

Molina Healthcare of California

3

Partnership Health Plan of California

29

San Francisco Health Plan

8

Santa Clara Family Health Plan

20

SCAN Health Plan

0

D1IV.16i

Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)

Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).

Aetna Better Health of California

1

AIDS Healthcare Foundation

0

Alameda Alliance for Health

82

Anthem Blue Cross

0

Blue Shield of California Promise

11

California Health and Wellness Plan

100

CalOptima

67

CalViva Health

199

CenCal Health

0

Central California Alliance for Health

7

Community Health Group

1

Contra Costa Health Plan

58

Gold Coast Health Plan

10

Health Net Community Solutions

835

Health Plan of San Joaquin

18

Health Plan of San Mateo

7

Inland Empire Health Plan

330

Kaiser Permanente

272

Kern Health Systems

31

L.A. Care Health Plan

260

Molina Healthcare of California

77

Partnership Health Plan of California

78

San Francisco Health Plan

18

Santa Clara Family Health Plan

31

SCAN Health Plan

0

D1IV.16j

Resolved grievances related to plan denial of expedited appeal

Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.

Aetna Better Health of California

0

AIDS Healthcare Foundation

0

Alameda Alliance for Health

1

Anthem Blue Cross

2

Blue Shield of California Promise

1

California Health and Wellness Plan

0

CalOptima

5

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

0

Community Health Group

0

Contra Costa Health Plan

4

Gold Coast Health Plan

0

Health Net Community Solutions

0

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

0

Kaiser Permanente

0

Kern Health Systems

1

L.A. Care Health Plan

2

Molina Healthcare of California

2

Partnership Health Plan of California

1

San Francisco Health Plan

0

Santa Clara Family Health Plan

1

SCAN Health Plan

0

D1IV.16k

Resolved grievances filed for other reasons

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.

Aetna Better Health of California

142

AIDS Healthcare Foundation

34

Alameda Alliance for Health

7,521

Anthem Blue Cross

2,527

Blue Shield of California Promise

809

California Health and Wellness Plan

669

CalOptima

6,005

CalViva Health

771

CenCal Health

61

Central California Alliance for Health

740

Community Health Group

188

Contra Costa Health Plan

592

Gold Coast Health Plan

278

Health Net Community Solutions

5,100

Health Plan of San Joaquin

1,292

Health Plan of San Mateo

393

Inland Empire Health Plan

29,206

Kaiser Permanente

1,947

Kern Health Systems

1,640

L.A. Care Health Plan

9,400

Molina Healthcare of California

5,118

Partnership Health Plan of California

2,109

San Francisco Health Plan

364

Santa Clara Family Health Plan

1,826

SCAN Health Plan

165

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Quality & performance measure total count: 15

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (WCV)

D2.VII.2 Measure Domain

Child & Adolescent Preventative Health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. assigned to the member.

Measure results

Aetna Better Health of California

29.78%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

49.69%

Anthem Blue Cross

45.90%

Blue Shield of California Promise

45.42%

California Health and Wellness Plan

42.22%

CalOptima

51.49%

CalViva Health

48.56%

CenCal Health

56.45%

Central California Alliance for Health

54.58%

Community Health Group

52.18%

Contra Costa Health Plan

53.09%

Gold Coast Health Plan

42.33%

Health Net Community Solutions

44.04%

Health Plan of San Joaquin

45.27%

Health Plan of San Mateo

52.00%

Inland Empire Health Plan

46.78%

Kaiser Permanente

Kaiser Norcal: 48.03% Kaiser SoCal: 48.33%

Kern Health Systems

40.64%

L.A. Care Health Plan

46.64%

Molina Healthcare of California

42.69%

Partnership Health Plan of California

45.19%

San Francisco Health Plan

56.28%

Santa Clara Family Health Plan

50.15%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Childhood Immunization Status: Combination 10 (CIS-10)

D2.VII.2 Measure Domain

Child & Adolescent Preventative Health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and

rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.

Measure results

Aetna Better Health of California

29.34%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

52.79%

Anthem Blue Cross

31.13%

Blue Shield of California Promise

43.05%

California Health and Wellness Plan

31.86%

CalOptima

39.42%

CalViva Health

29.57%

CenCal Health

44.75%

Central California Alliance for Health

37.96%

Community Health Group

40.16%

Contra Costa Health Plan

44.03%

Gold Coast Health Plan

40.88%

Health Net Community Solutions

25.75%

Health Plan of San Joaquin

30.61%

Health Plan of San Mateo

54.52%

Inland Empire Health Plan

28.95%

Kaiser Permanente

Kaiser Norcal: 49.45% Kasier SoCal: 50.97%

Kern Health Systems

27.98%

L.A. Care Health Plan

35.52%

Molina Healthcare of California

30.83%

Partnership Health Plan of California

37.26%

San Francisco Health Plan

57.67%

Santa Clara Family Health Plan

49.15%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents: Combination 2 (IMA-2)

3 / 15

D2.VII.2 Measure Domain

Child & Adolescent Preventative Health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

Measure results

Aetna Better Health of California

25.61%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

50.60%

Anthem Blue Cross

35.95%

Blue Shield of California Promise

34.82%

California Health and Wellness Plan

30.65%

CalOptima

51.82%

CalViva Health

39.98%

CenCal Health

48.38%

Central California Alliance for Health

47.67%

Community Health Group

42.58%

Contra Costa Health Plan

53.36%

Gold Coast Health Plan

35.78%

Health Net Community Solutions

37.49%

Health Plan of San Joaquin

34.96%

Health Plan of San Mateo

49.39%

Inland Empire Health Plan

34.55%

Kaiser Permanente

Kaiser Norcal: 63.16% Kaiser Socal: 56.50%

Kern Health Systems

29.69%

L.A. Care Health Plan

39.17%

Molina Healthcare of California

33.95%

Partnership Health Plan of California

42.75%

San Francisco Health Plan

54.82%

Santa Clara Family Health Plan

39.67%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Lead Screening in Children (LSC)

D2.VII.2 Measure Domain

Child & Adolescent Preventative Health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Measure results

Aetna Better Health of California

46.14%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

60.59%

Anthem Blue Cross

51.74%

Blue Shield of California Promise

65.47%

California Health and Wellness Plan

49.27%

CalOptima

63.02%

CalViva Health

52.11%

CenCal Health

59.49%

Central California Alliance for Health

66.70%

Community Health Group

67.89%

Contra Costa Health Plan

51.51%

Gold Coast Health Plan

65.69%

Health Net Community Solutions

51.21%

Health Plan of San Joaquin

43.56%

Health Plan of San Mateo

67.91%

Inland Empire Health Plan

52.07%

Kaiser Permanente

Kaiser Norcal: 45.09% Kaiser Socal: 49.61%

Kern Health Systems

47.44%

L.A. Care Health Plan

54.50%

Molina Healthcare of California

57.49%

Partnership Health Plan of California

43.97%

San Francisco Health Plan

74.48%

Santa Clara Family Health Plan

68.37%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After ED Visit for Mental Illness - 30 days

5 / 15

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional

self-harm, who had a follow-up visit for mental illness. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

Measure results

Aetna Better Health of California

45.19%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

49.03%

Anthem Blue Cross

50.59%

Blue Shield of California Promise

44.42%

California Health and Wellness Plan

55.03%

CalOptima

58.83%

CalViva Health

31.61%

CenCal Health

56.85%

Central California Alliance for Health

63.54%

Community Health Group

47.01%

Contra Costa Health Plan

45.97%

Gold Coast Health Plan

29.35%

Health Net Community Solutions

42.90%

Health Plan of San Joaquin

49.82%

Health Plan of San Mateo

69.70%

Inland Empire Health Plan

59.48%

Kaiser Permanente

Kaiser Norcal: 80.60% Kaiser Socal: 65.30%

Kern Health Systems

18.80%

L.A. Care Health Plan

35.70%

Molina Healthcare of California

39.03%

Partnership Health Plan of California

24.68%

San Francisco Health Plan

52.80%

Santa Clara Family Health Plan

64.73%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After ED Visit for Substance Abuse - 30 days

6 / 15

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

Measure results

Aetna Better Health of California

30.94%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

29.82%

Anthem Blue Cross

32.51%

Blue Shield of California Promise

33.55%

California Health and Wellness Plan

39.93%

CalOptima

24.05%

CalViva Health

19.58%

CenCal Health

38.41%

Central California Alliance for Health

33.77%

Community Health Group

N/A

Contra Costa Health Plan

26.61%

Gold Coast Health Plan

24.64%

Health Net Community Solutions

27.01%

Health Plan of San Joaquin

17.50%

Health Plan of San Mateo

53.44%

Inland Empire Health Plan

38.27%

Kaiser Permanente

Kaiser Norcal- 37.84% Kaiser SoCal-36.78%

Kern Health Systems

15.74%

L.A. Care Health Plan

26.15%

Molina Healthcare of California

28.59%

Partnership Health Plan of California

34.39%

San Francisco Health Plan

22.30%

Santa Clara Family Health Plan

32.16%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life - Well-C (W30 6+) Child Visits in the First 15 Months

D2.VII.2 Measure Domain

Child & Adolescent Preventative Health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits

Measure results

Aetna Better Health of California

27.73%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

46.56%

Anthem Blue Cross

50.36%

Blue Shield of California Promise

44.48%

California Health and Wellness Plan

52.49%

CalOptima

55.78%

CalViva Health

51.09%

CenCal Health

56.05%

Central California Alliance for Health

53.54%

Community Health Group

57.32%

Contra Costa Health Plan

65.88%

Gold Coast Health Plan

47.38%

Health Net Community Solutions

45.14%

Health Plan of San Joaquin

44.44%

Health Plan of San Mateo

49.62%

Inland Empire Health Plan

55.79%

Kaiser Permanente

Kaiser Norcal- 75.73% Kaiser SoCal-78.18%

Kern Health Systems

37.12%

L.A. Care Health Plan

45.63%

Molina Healthcare of California

35.79%

Partnership Health Plan of California

40.35%

San Francisco Health Plan

49.11%

Santa Clara Family Health Plan

54.46%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life - Well-C (W30 2+) Child Visits in the First 15 Months

8 / 15

D2.VII.2 Measure Domain

Child & Adolescent Preventative Health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Measure results

Aetna Better Health of California

49.30%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

69.01%

Anthem Blue Cross

64.27%

Blue Shield of California Promise

66.15%

California Health and Wellness Plan

63.78%

CalOptima

71.20%

CalViva Health

63.47%

CenCal Health

78.62%

Central California Alliance for Health

70.46%

Community Health Group

66.76%

Contra Costa Health Plan

73.05%

Gold Coast Health Plan

68.14%

Health Net Community Solutions

60.25%

Health Plan of San Joaquin

59.09%

Health Plan of San Mateo

72.38%

Inland Empire Health Plan

62.93%

Kaiser Permanente

Kaiser Norcal-73.45% Kaiser SoCal-68.19%

Kern Health Systems

55.12%

L.A. Care Health Plan

62.64%

Molina Healthcare of California

59.42%

Partnership Health Plan of California

61.96%

San Francisco Health Plan

75.97%

Santa Clara Family Health Plan

70.80%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Breast Cancer Screening (BCS)

D2.VII.2 Measure Domain

Women's/Maternity Heatlh

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Measure results

Aetna Better Health of California

40.35%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

56.13%

Anthem Blue Cross

47.07%

Blue Shield of California Promise

54.41%

California Health and Wellness Plan

51.28%

CalOptima

57.81%

CalViva Health

53.55%

CenCal Health

60.70%

Central California Alliance for Health

56.46%

Community Health Group

61.47%

Contra Costa Health Plan

63.95%

Gold Coast Health Plan

56.00%

Health Net Community Solutions

52.78%

Health Plan of San Joaquin

50.43%

Health Plan of San Mateo

58.68%

Inland Empire Health Plan

58.73%

Kaiser Permanente

Kaiser Norcal-76.78% Kaiser SoCal-77.14%

Kern Health Systems

56.68%

L.A. Care Health Plan

55.10%

Molina Healthcare of California

51.54%

Partnership Health Plan of California

53.45%

San Francisco Health Plan

61.92%

Santa Clara Family Health Plan

57.52%

SCAN Health Plan

79.62%

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening (CCS)

D2.VII.2 Measure Domain

Women's/Maternity Heatlh

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women 21–64 years of age who were screened for cervical cancer using any of the following criteria: • Women 21–64 years of age who had cervical cytology performed within the last 3 years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Measure results

Aetna Better Health of California

43.81%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

53.83%

Anthem Blue Cross

55.42%

Blue Shield of California Promise

53.42%

California Health and Wellness Plan

53.79%

CalOptima

57.73%

CalViva Health

57.69%

CenCal Health

63.39%

Central California Alliance for Health

63.84%

Community Health Group

58.15%

Contra Costa Health Plan

68.33%

Gold Coast Health Plan

57.91%

Health Net Community Solutions

54.64%

Health Plan of San Joaquin

57.41%

Health Plan of San Mateo

61.29%

Inland Empire Health Plan

56.97%

Kaiser Permanente

Kaiser Norcal-75.27% Kaiser SoCal-75.36%

Kern Health Systems

52.80%

L.A. Care Health Plan

54.43%

Molina Healthcare of California

51.90%

Partnership Health Plan of California

62.78%

San Francisco Health Plan

62.37%

Santa Clara Family Health Plan

59.85%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women (CHL)

11 / 15

D2.VII.2 Measure Domain

Women's/Maternity Heatlh

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Measure results

Aetna Better Health of California

62.22%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

64.14%

Anthem Blue Cross

60.28%

Blue Shield of California Promise

62.89%

California Health and Wellness Plan

51.15%

CalOptima

72.11%

CalViva Health

59.22%

CenCal Health

62.37%

Central California Alliance for Health

58.14%

Community Health Group

61.72%

Contra Costa Health Plan

66.65%

Gold Coast Health Plan

53.26%

Health Net Community Solutions

65.58%

Health Plan of San Joaquin

56.44%

Health Plan of San Mateo

67.39%

Inland Empire Health Plan

64.88%

Kaiser Permanente

Kaiser Norcal-65.20% Kaiser SoCal-64.51%

Kern Health Systems

53.67%

L.A. Care Health Plan

67.71%

Molina Healthcare of California

61.48%

Partnership Health Plan of California

57.21%

San Francisco Health Plan

66.79%

Santa Clara Family Health Plan

61.17%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Postpartum Care (PPC-Pst)

12 / 15

D2.VII.2 Measure Domain

Women's/Maternity Heatlh

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, the measure assesses the following facets of prenatal and postpartum care. • Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. • Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery

Measure results

Aetna Better Health of California

75%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

85.43%

Anthem Blue Cross

80.86%

Blue Shield of California Promise

84.61%

California Health and Wellness Plan

82.56%

CalOptima

81.16%

CalViva Health

84.51%

CenCal Health

91.57%

Central California Alliance for Health

89.73%

Community Health Group

80.78%

Contra Costa Health Plan

90.45%

Gold Coast Health Plan

86.39%

Health Net Community Solutions

78.35%

Health Plan of San Joaquin

79.45%

Health Plan of San Mateo

89.52%

Inland Empire Health Plan

79.63%

Kaiser Permanente

Kaiser Norcal-78.56% Kaiser SoCal-81.64%

Kern Health Systems

83.93%

L.A. Care Health Plan

80.74%

Molina Healthcare of California

80.96%

Partnership Health Plan of California

87.27%

San Francisco Health Plan

92.39%

Santa Clara Family Health Plan

78.34%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)

D2.VII.2 Measure Domain

Women's/Maternity Heatlh

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, the measure assesses the following facets of prenatal and postpartum care. • Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. • Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery

Measure results

Aetna Better Health of California

80.68%

AIDS Healthcare Foundation

N/A

Alameda Alliance for Health

87.49%

Anthem Blue Cross

87.66%

Blue Shield of California Promise

85.80%

California Health and Wellness Plan

88.79%

CalOptima

88.08%

CalViva Health

89.55%

CenCal Health

88.25%

Central California Alliance for Health

91.67%

Community Health Group

85.65%

Contra Costa Health Plan

93.85%

Gold Coast Health Plan

91.98%

Health Net Community Solutions

85.89%

Health Plan of San Joaquin

87.11%

Health Plan of San Mateo

90.68%

Inland Empire Health Plan

88.15%

Kaiser Permanente

Kaiser Norcal-91.07% Kaiser SoCal 95.17%

Kern Health Systems

87.35%

L.A. Care Health Plan

91.11%

Molina Healthcare of California

83.66%

Partnership Health Plan of California

89.08%

San Francisco Health Plan

89.70%

Santa Clara Family Health Plan

90.53%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC-H9)

D2.VII.2 Measure Domain

Chronic Disease

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: • HbA1c Poor Control (>9.0%).

Measure results

Aetna Better Health of California

49.92%

AIDS Healthcare Foundation

26.32%

Alameda Alliance for Health

29.20%

Anthem Blue Cross

37.41%

Blue Shield of California Promise

38.52%

California Health and Wellness Plan

34.59%

CalOptima

30.41%

CalViva Health

36.68%

CenCal Health

28.91%

Central California Alliance for Health

30.72%

Community Health Group

37.95%

Contra Costa Health Plan

33.98%

Gold Coast Health Plan

35.04%

Health Net Community Solutions

37.78%

Health Plan of San Joaquin

37.44%

Health Plan of San Mateo

34.43%

Inland Empire Health Plan

36.74%

Kaiser Permanente

Kaiser Norcal-30.85% Kaiser SoCal-22.45%

Kern Health Systems

39.17%

L.A. Care Health Plan

36.98%

Molina Healthcare of California

39.76%

Partnership Health Plan of California

33.61%

San Francisco Health Plan

33.98%

Santa Clara Family Health Plan

27.50%

SCAN Health Plan

13.60%

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure (CBP)

15 / 15

D2.VII.2 Measure Domain

Chronic Disease

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Measure results

Aetna Better Health of California

55.86%

AIDS Healthcare Foundation

71.82%

Alameda Alliance for Health

54.75%

Anthem Blue Cross

58.07%

Blue Shield of California Promise

70.01%

California Health and Wellness Plan

63.21%

CalOptima

65.85%

CalViva Health

63.18%

CenCal Health

59.26%

Central California Alliance for Health

64.26%

Community Health Group

65.21%

Contra Costa Health Plan

67.27%

Gold Coast Health Plan

60.34%

Health Net Community Solutions

61.28%

Health Plan of San Joaquin

59.54%

Health Plan of San Mateo

64.95%

Inland Empire Health Plan

65.32%

Kaiser Permanente

Kaiser Norcal-76.29% Kaiser SoCal-78.95%

Kern Health Systems

60.59%

L.A. Care Health Plan

62.76%

Molina Healthcare of California

59.70%

Partnership Health Plan of California

64.12%

San Francisco Health Plan

69.81%

Santa Clara Family Health Plan

60.59%

SCAN Health Plan

73.61%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Sanction total count: 50

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Anthem Blue Cross

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

84

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Health Net Community Solutions

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

66

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

3 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Molina Healthcare of California

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

33

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

4 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Aetna Better Health of California

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

23

D3.VIII.6 Sanction amount

$32,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

5 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Alameda Alliance for Health

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

$80,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

6 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Anthem Blue Cross

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

84

D3.VIII.6 Sanction amount

$323,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

7 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Blue Shield of California Promise

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

$32,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

8 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

California Health and Wellness Plan

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

23

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

9 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

CalViva Health

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$72,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

10 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Central California Alliance for Health

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

8

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

11 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Gold Coast Health Plan

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$33,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

12 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Health Net Community Solutions

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance
66

D3.VIII.6 Sanction amount
$655,000

D3.VIII.7 Date assessed
12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

13 / 50

D3.VIII.2 Intervention topic
Performance improvement

D3.VIII.3 Plan name
Health Plan of San Joaquin

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance
20

D3.VIII.6 Sanction amount
$108,000

D3.VIII.7 Date assessed
12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

14 / 50

D3.VIII.2 Intervention topic
Performance improvement

D3.VIII.3 Plan name
Inland Empire Health Plan

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

$416,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

15 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Kaiser Permanente

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

16 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Kaiser Permanente

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

17 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Kern Health Systems

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

10

D3.VIII.6 Sanction amount

$69,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

18 / 50

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

L.A. Care Health Plan

Performance improvement

D3.VIII.4 Reason for intervention

poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

$890,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

19 / 50

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Molina Healthcare of California

D3.VIII.4 Reason for intervention

poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance

33

D3.VIII.6 Sanction amount

$255,000

D3.VIII.7 Date assessed

12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Civil monetary penalty

20 / 50

Complete

D3.VIII.2 Intervention topic
Performance improvement

D3.VIII.3 Plan name
Partnership Health Plan of California

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2022

Sanction details

D3.VIII.5 Instances of non-compliance
31

D3.VIII.6 Sanction amount
$184,000

D3.VIII.7 Date assessed
12/29/2023

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

21 / 50

D3.VIII.2 Intervention topic
Network Adequacy

D3.VIII.3 Plan name
Molina Healthcare of California

D3.VIII.4 Reason for intervention

Managed Care identified missing items and denials of Alternative Access Standard requests (AAS). Managed care has placed the plan under CAP for administrative non-compliance in regards to time or distance.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
08/21/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 12/01/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

22 / 50

D3.VIII.2 Intervention topic

Network Adequacy

D3.VIII.3 Plan name

Anthem Blue Cross

D3.VIII.4 Reason for intervention

Managed Care identified missing items and denials of Alternative Access Standard requests (AAS). Managed Care has placed the plan under CAP for administrative non-compliance in regards to time or distance.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

08/21/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/01/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

23 / 50

D3.VIII.2 Intervention topic

Network Adequacy

D3.VIII.3 Plan name

California Health and Wellness Plan

D3.VIII.4 Reason for intervention

Managed Care identified missing items and denials of Alternative Access Standard requests (AAS). Managed Care has placed the plan under CAP for administrative non-compliance in regards to time or distance.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

08/21/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/01/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

24 / 50

D3.VIII.2 Intervention topic

Network Adequacy

D3.VIII.3 Plan name

Health Net Community Solutions

D3.VIII.4 Reason for intervention

Managed Care identified missing items and denials of Alternative Access Standard requests (AAS). Managed Care has placed the plan under CAP for administrative non-compliance in regards to time or distance.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

08/21/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/01/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

25 / 50

D3.VIII.2 Intervention topic

Untimely Payments for Physician Administered Drugs

D3.VIII.3 Plan name

Gold Coast Health Plan

D3.VIII.4 Reason for intervention

MCPs have been erroneously denying Physician Administered Drugs (PADs) billed as medical claims. DHCS developed PADs guidance for MCPs and providers, which was issued with an Advance Warning Letter indicating that reimbursements not provided within 30-days (by July 10, 2023), will trigger a CAP and potential penalties may be applied. Gold Coast owed $97.71 for 5 unpaid items. CAP items were received on 8/18/2023 and 9/18/23.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/19/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 09/21/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

26 / 50

D3.VIII.2 Intervention topic

Untimely Payments for Physician Administered Drugs

D3.VIII.3 Plan name

L.A. Care Health Plan

D3.VIII.4 Reason for intervention

MCPs have been erroneously denying Physician Administered Drugs (PADs) billed as medical claims. DHCS developed PADs guidance for MCPs and providers, which was issued with an Advance Warning Letter indicating that reimbursements not provided within 30-days (by July 10, 2023), will trigger a CAP and potential penalties may be applied. L.A. Care owed $29,335.01 for 217 unpaid items. CAP items were received on 8/25/2023. .

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/19/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 11/15/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

27 / 50

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

Untimely Payments for Physician Administered Drugs

Health Net Community Solutions

D3.VIII.4 Reason for intervention

MCPs have been erroneously denying Physician Administered Drugs (PADs) billed as medical claims. DHCS developed PADs guidance for MCPs and providers, which was issued with an Advance Warning Letter indicating that reimbursements not provided within 30-days (by July 10, 2023), will trigger a CAP and potential penalties may be applied. Health Net owed $41,552.06 for 659 unpaid items. CAP items were received on 8/18/2023.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/19/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 11/15/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

28 / 50

D3.VIII.2 Intervention topic

Member's Rights and Quality Managment

D3.VIII.3 Plan name

Aetna Better Health of California

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/29/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/29/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

29 / 50

D3.VIII.2 Intervention topic

Utilization Management • Case Management and Coordination of Care • Access and Availability of Care • Member's Rights • State Supported Service

D3.VIII.3 Plan name

Alameda Alliance for Health

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

15

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/23/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

30 / 50

D3.VIII.2 Intervention topic

Access and Availability of Care • Member's Rights

D3.VIII.3 Plan name

Anthem Blue Cross

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/20/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 10/13/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

31 / 50

D3.VIII.2 Intervention topic

Administrative and Organizational Capacity

D3.VIII.3 Plan name

Blue Shield of California Promise

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

08/08/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 11/02/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

32 / 50

D3.VIII.2 Intervention topic

Utilization Management
• Case Management and Coordination of Care

D3.VIII.3 Plan name

California Health and Wellness Plan

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

8

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/14/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 10/25/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

33 / 50

D3.VIII.2 Intervention topic

Utilization Management
• Member's Rights

D3.VIII.3 Plan name

California Health and Wellness Plan

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

11/15/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

34 / 50

D3.VIII.2 Intervention topic

Case Management and Coordination of Care

D3.VIII.3 Plan name

CalOptima

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
08/18/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 12/29/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

35 / 50

D3.VIII.2 Intervention topic
Member's Rights

D3.VIII.3 Plan name
CalViva Health

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
09/20/2023

D3.VIII.8 Remediation date non-compliance was corrected
Remediation in progress

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

36 / 50

D3.VIII.2 Intervention topic
Utilization Management • Case Management and Coordination of Care • Access and Availability of Care

D3.VIII.3 Plan name
Community Health Group

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/17/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

37 / 50

D3.VIII.2 Intervention topic

Utilization Management
Member's Rights

D3.VIII.3 Plan name

Community Health Group

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

8

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/07/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

38 / 50

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

Contra Costa Health Plan

Utilization Management • Case Management and Coordination of Care • Access and Availability of Care • Member's Rights • Quality Management • State Supported Services

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/20/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

39 / 50

D3.VIII.2 Intervention topic

Case Management and Coordination of Care • Access and Availability of Care • Quality Management

D3.VIII.3 Plan name

Gold Coast Health Plan

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/17/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 09/19/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

40 / 50

D3.VIII.2 Intervention topic

Utilization Management • Case Management and Coordination of Care • Access and Availability of Care • Member's Rights

D3.VIII.3 Plan name

Health Plan of San Joaquin

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

9

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/01/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/29/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

41 / 50

D3.VIII.2 Intervention topic

Utilization Management • Access and Availability of Care • Member's Rights • Administrative and Organizational Capacity

D3.VIII.3 Plan name

Inland Empire Health Plan

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/21/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

42 / 50

D3.VIII.2 Intervention topic

Utilization Management • Case Management and Coordination of Care • Access and Availability of Care • Member's Rights • Administrative and Organizational Capacity

D3.VIII.3 Plan name

Kaiser Permanente

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

30

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/27/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 11/06/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

43 / 50

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

Kaiser Permanente

Utilization Management • Case Management and Coordination of Care • Access and Availability of Care • Member's Rights • Administrative and Organizational Capacity

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

32

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/27/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 11/06/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

44 / 50

D3.VIII.2 Intervention topic

Utilization Management • Case Management and Coordination of Care • Access and Availability of Care • Member's Rights • Quality Management • Administrative and Organizational Capacity • State Supported Services

D3.VIII.3 Plan name

Kern Health Systems

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

29

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/09/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

45 / 50

D3.VIII.2 Intervention topic

Utilization Management • Case Management and Coordination of Care • Member's Rights • Quality Management

D3.VIII.3 Plan name

L.A. Care Health Plan

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

11/08/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

46 / 50

D3.VIII.2 Intervention topic

Access and Availability of Care • Member's Rights • Quality Management

D3.VIII.3 Plan name

Molina Healthcare of California

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

04/21/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 10/30/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

47 / 50

D3.VIII.2 Intervention topic

Case Management and Coordination of Care • Access and Availability of Care

D3.VIII.3 Plan name

Partnership Health Plan of California

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

04/12/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 10/23/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

48 / 50

D3.VIII.2 Intervention topic

Utilization Management • Case Management and

D3.VIII.3 Plan name

San Francisco Health Plan

Coordination of Care • Access and Availability of Care • Quality Management

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/19/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

49 / 50

D3.VIII.2 Intervention topic

Utilization Management • Case Management and Coordination of Care • Access and Availability of Care • Member's Rights • Quality Management • Administrative and Organizational Capacity

D3.VIII.3 Plan name

Santa Clara Family Health Plan

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

18

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/20/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 10/02/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan 50 / 50

D3.VIII.2 Intervention topic

Utilization Management Member's Rights

D3.VIII.3 Plan name

SCAN Health Plan

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/28/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 01/29/2024

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Aetna Better Health of California** 6 **AIDS Healthcare Foundation** 3 **Alameda Alliance for Health** 20 **Anthem Blue Cross** 24 **Blue Shield of California Promise** 7 **California Health and Wellness Plan** 15 **CalOptima** 9 **CalViva Health** 5 **CenCal Health** 8 **Central California Alliance for Health** 8 **Community Health Group** 5 **Contra Costa Health Plan** 2 **Gold Coast Health Plan**

5

Health Net Community Solutions

37

Health Plan of San Joaquin

20

Health Plan of San Mateo

14

Inland Empire Health Plan

6

Kaiser Permanente

79

Kern Health Systems

8

L.A. Care Health Plan

15

Molina Healthcare of California

92

Partnership Health Plan of California

6

San Francisco Health Plan

12

Santa Clara Family Health Plan

8

SCAN Health Plan

3

D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Aetna Better Health of California** 7 **AIDS Healthcare Foundation** 0 **Alameda Alliance for Health** 43 **Anthem Blue Cross** 17 **Blue Shield of California Promise** 144 **California Health and Wellness Plan** 26 **CalOptima** 75 **CalViva Health** 3 **CenCal Health** 52 **Central California Alliance for Health** 55 **Community Health Group** 3 **Contra Costa Health Plan** 6 **Gold Coast Health Plan** 23

		Health Net Community Solutions 111 **Health Plan of San Joaquin** 26 **Health Plan of San Mateo** 8 **Inland Empire Health Plan** 264 **Kaiser Permanente** 89 **Kern Health Systems** 145 **L.A. Care Health Plan** 356 **Molina Healthcare of California** 225 **Partnership Health Plan of California** 47 **San Francisco Health Plan** 26 **Santa Clara Family Health Plan** 8 **SCAN Health Plan** 23
D1X.3	**Ratio of opened program integrity investigations to enrollees**	**Aetna Better Health of California** 0.1:1,000

What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.

AIDS Healthcare Foundation

0:1,000

Alameda Alliance for Health

0.12:1,000

Anthem Blue Cross

0.01:1,000

Blue Shield of California Promise

0.95:1,000

California Health and Wellness Plan

0.1:1,000

CalOptima

0.08:1,000

CalViva Health

0.007:1,000

CenCal Health

0.22:1,000

Central California Alliance for Health

0.13:1,000

Community Health Group

0.008:1,000

Contra Costa Health Plan

0.02:1,000

Gold Coast Health Plan

0.09:1,000

Health Net Community Solutions

0.06:1,000

Health Plan of San Joaquin

0.06:1,000

Health Plan of San Mateo

0.05:1,000

Inland Empire Health Plan

0.16:1,000

Kaiser Permanente

0.4:1,000

Kern Health Systems

0.39:1,000

L.A. Care Health Plan

0.12:1,000

Molina Healthcare of California

0.39:1,000

Partnership Health Plan of California

0.07:1,000

San Francisco Health Plan

0.13:1,000

Santa Clara Family Health Plan

0.02:1,000

SCAN Health Plan

1.1:1,000

D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Aetna Better Health of California** 6 **AIDS Healthcare Foundation** 0

Alameda Alliance for Health

9

Anthem Blue Cross

6

Blue Shield of California Promise

79

California Health and Wellness Plan

10

CalOptima

39

CalViva Health

2

CenCal Health

37

Central California Alliance for Health

31

Community Health Group

0

Contra Costa Health Plan

2

Gold Coast Health Plan

5

Health Net Community Solutions

48

Health Plan of San Joaquin

10

Health Plan of San Mateo

3

Inland Empire Health Plan

219

Kaiser Permanente

70

Kern Health Systems

97

L.A. Care Health Plan

114

Molina Healthcare of California

168

Partnership Health Plan of California

31

San Francisco Health Plan

11

Santa Clara Family Health Plan

4

SCAN Health Plan

6

D1X.5

Ratio of resolved program integrity investigations to enrollees

What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.

Aetna Better Health of California

0.09:1,000

AIDS Healthcare Foundation

0:1,000

Alameda Alliance for Health

0.03:1,000

Anthem Blue Cross

0.005:1,000

Blue Shield of California Promise

0.52:1,000

California Health and Wellness Plan

0.04:1,000

CalOptima

0.04:1,000

CalViva Health

0.004:1,000

CenCal Health

0.16:1,000

Central California Alliance for Health

0.07:1,000

Community Health Group

0:1,000

Contra Costa Health Plan

0.007:1,000

Gold Coast Health Plan

0.02:1,000

Health Net Community Solutions

0.03:1,000

Health Plan of San Joaquin

0.02:1,000

Health Plan of San Mateo

0.02:1,000

Inland Empire Health Plan

0.13:1,000

Kaiser Permanente

0.31:1,000

Kern Health Systems

0.26:1,000

L.A. Care Health Plan

0.04:1,000

Molina Healthcare of California

0.29:1,000

Partnership Health Plan of California

0.04:1,000

San Francisco Health Plan

0.06:1,000

Santa Clara Family Health Plan

0.01:1,000

SCAN Health Plan

0.3:1,000

D1X.6

Referral path for program integrity referrals to the state

What is the referral path that the plan uses to make program integrity referrals to the state? Select one.

Aetna Better Health of California

Makes some referrals to the SMA and others directly to the MFCU

AIDS Healthcare Foundation

Makes some referrals to the SMA and others directly to the MFCU

Alameda Alliance for Health

Makes some referrals to the SMA and others directly to the MFCU

Anthem Blue Cross

Makes some referrals to the SMA and others directly to the MFCU

Blue Shield of California Promise

Makes some referrals to the SMA and others directly to the MFCU

California Health and Wellness Plan

Makes some referrals to the SMA and others directly to the MFCU

CalOptima

Makes some referrals to the SMA and others directly to the MFCU

CalViva Health

Makes some referrals to the SMA and others directly to the MFCU

CenCal Health

Makes some referrals to the SMA and others directly to the MFCU

Central California Alliance for Health

Makes some referrals to the SMA and others directly to the MFCU

Community Health Group

Makes some referrals to the SMA and others directly to the MFCU

Contra Costa Health Plan

Makes some referrals to the SMA and others directly to the MFCU

Gold Coast Health Plan

Makes some referrals to the SMA and others directly to the MFCU

Health Net Community Solutions

Makes some referrals to the SMA and others directly to the MFCU

Health Plan of San Joaquin

Makes some referrals to the SMA and others directly to the MFCU

Health Plan of San Mateo

Makes some referrals to the SMA and others directly to the MFCU

Inland Empire Health Plan

Makes some referrals to the SMA and others directly to the MFCU

Kaiser Permanente

Makes some referrals to the SMA and others directly to the MFCU

Kern Health Systems

Makes some referrals to the SMA and others directly to the MFCU

L.A. Care Health Plan

Makes some referrals to the SMA and others directly to the MFCU

Molina Healthcare of California

Makes some referrals to the SMA and others directly to the MFCU

Partnership Health Plan of California

Makes some referrals to the SMA and others directly to the MFCU

San Francisco Health Plan

Makes some referrals to the SMA and others directly to the MFCU

Santa Clara Family Health Plan

Makes some referrals to the SMA and others directly to the MFCU

SCAN Health Plan

Makes some referrals to the SMA and others directly to the MFCU

D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Aetna Better Health of California** 7 **AIDS Healthcare Foundation** 0 **Alameda Alliance for Health** 43 **Anthem Blue Cross** 17 **Blue Shield of California Promise** 144 **California Health and Wellness Plan** 26 **CalOptima** 75 **CalViva Health** 3 **CenCal Health** 52 **Central California Alliance for Health** 55 **Community Health Group** 3 **Contra Costa Health Plan** 6

Gold Coast Health Plan

23

Health Net Community Solutions

111

Health Plan of San Joaquin

26

Health Plan of San Mateo

8

Inland Empire Health Plan

264

Kaiser Permanente

89

Kern Health Systems

145

L.A. Care Health Plan

356

Molina Healthcare of California

225

Partnership Health Plan of California

47

San Francisco Health Plan

26

Santa Clara Family Health Plan

8

SCAN Health Plan

23

D1X.8

Ratio of program integrity referral to the state

What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.

Aetna Better Health of California

0.1:1,000

AIDS Healthcare Foundation

0:1,000

Alameda Alliance for Health

0.12:1,000

Anthem Blue Cross

0.02:1,000

Blue Shield of California Promise

0.95:1,000

California Health and Wellness Plan

0.1:1,000

CalOptima

0.08:1,000

CalViva Health

0.007:1,000

CenCal Health

0.22:1,000

Central California Alliance for Health

0.13:1,000

Community Health Group

0.008:1,000

Contra Costa Health Plan

0.022:1,000

Gold Coast Health Plan

0.1:1,000

Health Net Community Solutions

0.00006:1,000

Health Plan of San Joaquin

0.061:1,000

Health Plan of San Mateo

0.05:1,000

Inland Empire Health Plan

0.0002:1,000

Kaiser Permanente

0.4:1,000

Kern Health Systems

0.0004:1,000

L.A. Care Health Plan

0.0001:1,000

Molina Healthcare of California

0.39:1,000

Partnership Health Plan of California

0.07:1,000

San Francisco Health Plan

0.13:1,000

Santa Clara Family Health Plan

0.02:1,000

SCAN Health Plan

1.2:1,000

D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery	**Aetna Better Health of California** For January 2022 through June 2023: - Total overpayments by MCP: $400,081.27 - Total

report submitted to the state as required under 42 CFR 438.608(d)(3).
Include, at minimum, the following information:

- The date of the report (rating period or calendar year).
- The dollar amount of overpayments recovered.
- The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).

overpayments recovered by MCP: $126,229.51 - Net overpayments by MCP: $273,851.76 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

AIDS Healthcare Foundation

For January 2022 through December 2022: - Total overpayments by MCP: $17,548. - Total overpayments recovered by MCP: $17,548. - Net overpayments by MCP: $. - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

Alameda Alliance for Health

For January 2022 through June 2023: - Total overpayments by MCP: $4,118,217.67 - Total overpayments recovered by MCP: $4,118,217.67 - Net overpayments by MCP: $. - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

Anthem Blue Cross

For January 2022 through June 2023: - Total overpayments by MCP: $31,736,094.3 - Total overpayments recovered by MCP: $24,630,811.37 - Net overpayments by MCP: $7,105,282.93 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

Blue Shield of California Promise

For January 2022 through June 2023: - Total overpayments by MCP: $23,772,973.91 - Total overpayments recovered by MCP: $11,200,222.71 - Net overpayments by MCP: $12,572,751.2 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of premium: 0.006%

California Health and Wellness Plan

For January 2022 through June 2023: - Total overpayments by MCP: $34,657,607.96 - Total

overpayments recovered by MCP: $33,454,796.3 - Net overpayments by MCP: $1,202,811.66 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.002%

CalOptima

For January 2022 through June 2023: - Total overpayments by MCP: $18,881,216.47 - Total overpayments recovered by MCP: $18,528,949.61 - Net overpayments by MCP: $352,266.86 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.002%

CalViva Health

For January 2022 through June 2023: - Total overpayments by MCP: $21,575,910.28 - Total overpayments recovered by MCP: $20,129,892.33 - Net overpayments by MCP: $1,446,017.94 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

CenCal Health

For January 2022 through June 2023: - Total overpayments by MCP: $26,915,470.3 - Total overpayments recovered by MCP: $26,915,470.3 - Net overpayments by MCP: $. - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of premium: 0.046%

Central California Alliance for Health

For January 2022 through June 2023: - Total overpayments by MCP: $44,713,429.3 - Total overpayments recovered by MCP: $42,787,884.92 - Net overpayments by MCP: $1,925,544.38 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

Community Health Group

For January 2022 through June 2023: - Total overpayments by MCP: $3,921,544.28 - Total overpayments recovered by MCP: $2,377,539.52 - Net overpayments by MCP: $1,544,004.76 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

Contra Costa Health Plan

For January 2022 through June 2023: - Total overpayments by MCP: $249,360.28 - Total overpayments recovered by MCP: $249,360.28 - Net overpayments by MCP: $. - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

Gold Coast Health Plan

For January 2022 through June 2023: - Total overpayments by MCP: $2,881,765.16 - Total overpayments recovered by MCP: $2,881,765.16 - Net overpayments by MCP: $. - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

Health Net Community Solutions

For January 2022 through June 2023: - Total overpayments by MCP: $35,448,996.22 - Total overpayments recovered by MCP: $29,900,979.46 - Net overpayments by MCP: $5,548,016.76 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

Health Plan of San Joaquin

For January 2022 through June 2023: - Total overpayments by MCP: $7,750,127.78 - Total overpayments recovered by MCP: $5,834,746.13 - Net overpayments by MCP: $1,915,381.65 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

Health Plan of San Mateo

For January 2022 through June 2023: - Total overpayments by MCP: $12,500,159.98 - Total overpayments recovered by MCP: $7,437,773.01 - Net overpayments by MCP: $5,062,386.97 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of premium: 0.125%

Inland Empire Health Plan

For January 2022 through June 2023: - Total overpayments by MCP: $31,540,203.03 - Total overpayments recovered by MCP: $17,202,427.79 - Net overpayments by MCP: $14,337,775.24 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

Kaiser Permanente

For January 2022 through June 2023: - Total overpayments by MCP: $15,457,574.89 - Total overpayments recovered by MCP: $5,681,508.33 - Net overpayments by MCP: $9,776,066.56 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.003%

Kern Health Systems

For January 2022 through June 2023: - Total overpayments by MCP: $6,210,373.25 - Total overpayments recovered by MCP: $4,573,083.77 - Net overpayments by MCP: $1,637,289.48 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

L.A. Care Health Plan

For January 2022 through June 2023: - Total overpayments by MCP: $99,964,909.36 - Total overpayments recovered by MCP: $76,701,329.23 - Net overpayments by MCP: $23,263,580.13 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of premium: 0.121%

Molina Healthcare of California

For January 2022 through June 2023: - Total overpayments by MCP: $18,090,031.17 - Total overpayments recovered by MCP: $18,090,031.17 - Net overpayments by MCP: $. - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

Partnership Health Plan of California

For January 2022 through June 2023: - Total overpayments by MCP: $4,393,139.92 - Total overpayments recovered by MCP: $1,672,880.78 - Net overpayments by MCP: $2,720,259.14 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

San Francisco Health Plan

For January 2022 through June 2023: - Total overpayments by MCP: $1,882,730.81 - Total overpayments recovered by MCP: $1,882,730.81 - Net overpayments by MCP: $. - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

Santa Clara Family Health Plan

For January 2022 through June 2023: - Total overpayments by MCP: $5,709,924.72 - Total overpayments recovered by MCP: $4,822,443.92 - Net overpayments by MCP: $887,480.8 - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

SCAN Health Plan

For January 2022 through December 2022: - Total overpayments by MCP: $16,600. - Total overpayments recovered by MCP: $10,478. - Net overpayments by MCP: $6,122. - Total overpayments paid back to DHCS: $0.00 - Ratio of dollar amount of overpayments recovered as a percent of to DHCS: 0.000%

D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Aetna Better Health of California** Promptly when plan receives information about the change **AIDS Healthcare Foundation** Promptly when plan receives information about the change **Alameda Alliance for Health** Promptly when plan receives information about the change **Anthem Blue Cross** Promptly when plan receives information about the change **Blue Shield of California Promise** Promptly when plan receives information about the change **California Health and Wellness Plan** Promptly when plan receives information about the change **CalOptima** Promptly when plan receives information about the change **CalViva Health** Promptly when plan receives information about the change **CenCal Health** Promptly when plan receives information about the change **Central California Alliance for Health** Promptly when plan receives information about the change **Community Health Group**

Promptly when plan receives information about the change

Contra Costa Health Plan

Promptly when plan receives information about the change

Gold Coast Health Plan

Promptly when plan receives information about the change

Health Net Community Solutions

Promptly when plan receives information about the change

Health Plan of San Joaquin

Promptly when plan receives information about the change

Health Plan of San Mateo

Promptly when plan receives information about the change

Inland Empire Health Plan

Promptly when plan receives information about the change

Kaiser Permanente

Promptly when plan receives information about the change

Kern Health Systems

Promptly when plan receives information about the change

L.A. Care Health Plan

Promptly when plan receives information about the change

Molina Healthcare of California

Promptly when plan receives information about the change

Partnership Health Plan of California

Promptly when plan receives information about the change

San Francisco Health Plan

Promptly when plan receives information about the change

Santa Clara Family Health Plan

Promptly when plan receives information about the change

SCAN Health Plan

Promptly when plan receives information about the change

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus** Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus** Enrollment Broker/Choice Counseling Beneficiary Outreach LTSS Complaint Access Point LTSS Grievance/Appeals Education LTSS Grievance/Appeals Assistance Review/Oversight of LTSS Data