Managed Care Program Annual Report (MCPAR) for California: Medi-Cal Managed Care program (MCMC)

Due date	Last edited	Edited by	Status
06/29/2025	09/25/2025	Bao Her	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
	Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If “No”, please complete the following questions under each plan.	No

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.	Sabrina Wisdom
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	sabrina.wisdom@dhcs.ca.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	10/01/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2024
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2024
A6	**Program name** Auto-populated from report dashboard.	Medi-Cal Managed Care program (MCMC)

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	Positive Health Care
	Alameda Alliance for Health
	Anthem Blue Cross Partnership Health Plan
	Blue Shield of California Promise Health Plan
	CalOptima Health
	CalViva Health
	CenCal Health
	Central California Alliance for Health
	Community Health Group Partnership Plan
	Community Health Plan of Imperial Valley
	Contra Costa Health Plan
	Gold Coast Health Plan
	Health Net Community Solutions, Inc.
	Health Plan of San Joaquin
	Health Plan of San Mateo
	Inland Empire Health Plan
	Kaiser Foundation Health Plan, Inc.
	Kern Family Health Care
	L.A. Care Health Plan
	Molina Healthcare of California
	Partnership HealthPlan 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 438.71. See 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, Enrollment Broker

Add In Lieu of Services and Settings (A.9)

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

Indicator	Response
ILOS name	Not answered

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.	14,980,562
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.	14,000,060

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 Other, specify – DHCS Post Adjudicated Claims & Encounter System (PACES)

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).	Exhibit A, Attachment III, 1.3.6 Treatment of Overpayment Recoveries 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.4	**Description of overpayment contract standard** Briefly describe the overpayment standard 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 DHCS Audits and InvestigationsUnit. 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	Yes

	reporting performance? Select one.	
BX.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	Managed Care Plans are contractually obligated to notify DHCS within ten working days of removing a suspended, excluded, or terminated provider from its Provider Network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. This information is collected from MCPs by DHCS' Medi-Cal Managed Care Program/Program Integrity Unit. The state has a field in the case management system that tracks the date plans removed a provider from their network. This new field allows the state to monitor if plans are notifying the state within 10 days of removing a provider from their network.
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 42 CFR 438.602(g)(3) and 455.104.	Yes
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's behalf. DHCS is fully compliant with both 42 CFR 438.602(e) and 438.602.(g)(4). DHCS has continued to perform Rate Development 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

Topic XIII. Prior Authorization

Beginning June 2026, Indicators B.XIII.1a-b–2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?**	Yes
BXIII.1a	**Timeframes for standard prior authorization decisions** Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and within state-established timeframes. For rating periods that start before January 1, 2026, a state's time frame may not exceed 14 calendar days after receiving the request. For rating periods that start on or after January 1, 2026, a state's time frame may not exceed 7 calendar days after receiving the request. Does the state set timeframes shorter than these maximum timeframes for standard prior authorization requests?	No
BXIII.2a	**Timeframes for expedited prior authorization decisions** Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and no later than 72 hours after receipt of the request for service. Does the state set timeframes shorter than the maximum timeframe for expedited prior authorization requests?	No

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.	Medi-Cal Managed Care Plan (MCP) Contract January 1, 2024 Senior Care Action Network (SCAN) Plan FIDE SNP Contract January 1, 2008
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2024
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/Documents/2024-Managed-Care-Boilerplate-Contract.pdf
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.	Dental is a benefit covered under Health Plan of San Mateo through a pilot program.
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per	13,994,032

	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.	Benefit Changes: Effective July 1, 2024, Specialty Mental Health Services (SMHS) in Sacramento and Solano counties were no longer capitated to the Kaiser Permanente Health Plan. SMHS is delivered by Mental Health Plans the same as in all other counties. 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, 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, 2024, Kaiser Permanente implemented the Whole Child Model (WCM) program that incorporates California Children's Services (CCS) program covered services for Medi-Cal eligible CCS children and youth in existing WCM Counties (Marin, Napa, Orange, San Mateo, Santa Cruz, Solano, Sonoma, Yolo). Enrollment Changes: 2024 Managed Care Plan Transition: Approximately 1.2 million members were identified to transition to a new MCP on January 1, 2024, as a result of Medi-Cal transformation and the new managed care contract. In addition, Kaiser became the prime MCP for approximately 800,000 members. This change took place across 21 counties and 14 unique MCPs. Adult Expansion Transition: The Adult Expansion Transition was implemented on January 1, 2024, and provides full scope Medi-Cal to Californians 26-49 years of age, regardless of immigration status, if they meet all Medi-Cal eligibility criteria. With this expansion, full scope Medi-Cal coverage is now available to all otherwise eligible Californians, regardless of immigration status. The Adult Expansion transition impacted approximately 707,000 individuals. Long Term Care Phase II: Approximately 4,700 members were identified to transition from Fee-for-Service to a MCP on January 1, 2024, when long term care ICF/DD and subacute care benefits were carved into managed care benefit. With the completion of this final phase of the Long-Term Care

	transition, the LTC benefit has been carved-in statewide and LTC FFS members have transitioned to managed care.

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).	Timeliness of initial data submissions Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation) Other, specify – 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.	Exhibit A, Attachment III, Subsection 2.1.2 (Encounter Data Reporting)

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 standards. Use contract section references, not page numbers.	Exhibit E, Section 1.19 (Sanctions)
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.	Managed Care Plans (MCPs) are incentivized to provide accurate and complete encounter data as part of the Auto Assignment Incentive Program (AAIP). The AAIP is designed to reward MCPs with higher performance on select quality measures with additional Medi-Cal membership by assigning more members to better-performing MCPs. Historically, Safety Net Primary Care Provider (PCP) Assignment as detailed in Assembly Bill (AB) 85 (Chapter 24, Statues of 2013) and Encounter Data Quality were part of AAIP. Going forward, they are independently assessed and monitored by the program and are not factored into the methodology unless a plan is out of compliance with AB 85, in which case the AAIP program will be adjusted per AB 85 requirements.
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 did not experience any barriers to collecting or validating encounter data during the reporting year.

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.	DHCS defines critical incidents as the following: 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 day the MCO, PIHP or PAHP receives the grievance.	For standard grievances: 30 calendar days For expedited grievances: 72 hours

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: 40

Complete

C2.V.3 Standard type: Maximum time or distance

1 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

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.3 Standard type: Maximum time or distance

2 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Maximum time or distance

3 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	small counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Maximum time or distance

4 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	medium counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Maximum time or distance

5 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Dense counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Maximum time or distance

6 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Maximum time or distance

7 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Maximum time or distance

8 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Small counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Maximum time or distance

9 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Medium counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Maximum time or distance

10 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Dense counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Maximum time or distance

11 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

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.3 Standard type: Maximum time or distance

12 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Mental health: 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.3 Standard type: Maximum time or distance

13 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Maximum time or distance

14 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Mental health: 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.3 Standard type: Maximum time or distance

15 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Mental health: 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.3 Standard type: Appointment wait time

16 / 40

C2.V.2 Measure standard

Within 10 business days of the request for appointment

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

17 / 40

C2.V.2 Measure standard

Within 15 business days of the request for appointment

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

18 / 40

C2.V.2 Measure standard

Within 10 business days of the request for appointment

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Statewide	All applicable populations

C2.V.7 Monitoring Methods

Custom method - External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

19 / 40

C2.V.2 Measure standard

Within 15 business days of the request for appointment

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Statewide	All applicable populations

C2.V.7 Monitoring Methods

Custom method - External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

20 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

21 / 40

C2.V.2 Measure standard

Preventive: Within 40 business days of the request for appointment

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

22 / 40

C2.V.2 Measure standard

Within 10 business days of the request for appointment

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - External Quality Review Organization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

23 / 40

C2.V.2 Measure standard

Within 14 calendar days of request

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

24 / 40

C2.V.2 Measure standard

Within 14 calendar days of request

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

25 / 40

C2.V.2 Measure standard

Within 7 business days of request

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

26 / 40

C2.V.2 Measure standard

Within 5 business days of request

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

27 / 40

C2.V.2 Measure standard

Within 14 calendar days of request

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

28 / 40

C2.V.2 Measure standard

Within 14 calendar days of request

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

29 / 40

C2.V.2 Measure standard

Within 7 business days of request

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

30 / 40

C2.V.2 Measure standard

Within 5 business days of request

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider
LTSS

C2.V.5 Region
Dense counties

C2.V.6 Population
Adult and pediatric

C2.V.7 Monitoring Methods
Custom method - Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods
Annually

Complete

C2.V.3 Standard type: Appointment wait time

31 / 40

C2.V.2 Measure standard
Capacity cannot decrease in aggregate statewide below April 2012 level

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

C2.V.4 Provider
LTSS

C2.V.5 Region
Rural

C2.V.6 Population
Adult and pediatric

C2.V.7 Monitoring Methods
Custom method - Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods
Annually

Complete

C2.V.3 Standard type: Appointment wait time

32 / 40

C2.V.2 Measure standard
Capacity cannot decrease in aggregate statewide below April 2012 level

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

C2.V.4 Provider
LTSS

C2.V.5 Region
Small counties

C2.V.6 Population
Adult and pediatric

C2.V.7 Monitoring Methods
Custom method - Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

33 / 40

C2.V.2 Measure standard

Capacity cannot decrease in aggregate statewide below April 2012 level

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Appointment wait time

34 / 40

C2.V.2 Measure standard

Capacity cannot decrease in aggregate statewide below April 2012 level

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan Policy & Procedure Review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Ease of getting a timely appointment

35 / 40

C2.V.2 Measure standard

10 minutes from the time the call is placed

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - External Quality Review Organnization

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Provider to enrollee ratios

36 / 40

C2.V.2 Measure standard

1 Full-Time Equivalent PCP to 2,000 Members

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Provider to enrollee ratios

37 / 40

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Provider to enrollee ratios

38 / 40

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.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Minimum number of network providers

39 / 40

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.1 General category

General quantitative availability and accessibility standard

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

C2.V.7 Monitoring Methods

Custom method - Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.3 Standard type: Minimum number of network providers

40 / 40

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.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist: Indian Care Health Provider	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - 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.	Beneficiary support systems are accessible by phone, internet, and in person through DHCS Health Care Options (HCO) enrollment broker, Maximus. Beneficiary support systems includes a Telephone Call Center (TCC), HCO website (https://www.healthcareoptions.dhcs.ca.gov), and In-Person support services. The TCC assists applicants or beneficiaries in understanding, selecting, and enrolling in a Medi-Cal managed care plan. The TCC is accessible through a statewide toll-free helpline and staffed to provide information and assistance in all threshold languages. TCC provides a Telecommunications Device for the Deaf (TDD)/Teletypewriter (TTY) telephone line with a messaging system for the hearing impaired that is available during normal business hours and has a call back option available after normal business hours. The HCO website provides health care options, program information, and answers to frequently asked questions. HCO website also provides access to informing materials, choice, forms, in-person presentation schedules, lists of health plans and links to health plan websites, Provider Information Network, eligibility status, and Beneficiary enrollment information. The website also provides a help page and a link to request assistance, email questions and comments online. HCO CSP website is in compliance with the California Web Accessibility Standards and applicable provisions of the Americans with Disability Act (ADA). 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

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	**Did the State or MCOs complete the most recent parity analysis(es)?**	State
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	No
C1XII.8	**When was the last parity analysis(es) for this program completed?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	10/02/2017
C1XII.9	**When was the last parity analysis(es) for this program**	10/02/2017

	submitted to CMS? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	Yes
C1XII.10b	**In the last analysis(es) conducted, describe all deficiencies identified.**	DHCS identified the following deficiencies under the Managed Care Plan delivery system: 1. DHCS identified deficiencies regarding AMSC quantitative limits on screenings and brief interventions and were addressed in APL 17-016. 2. DHCS identified deficiencies regarding AMSC provider training requirements and were addressed in APL 17-016. 3. DHCS identified deficiencies regarding Prior authorization processes for non-specialty mental health services and were addressed in APL 17-018. 4. DHCS identified deficiencies regarding Statewide Network Adequacy standards and were addressed in APL 20-003. 5. DHCS identified deficiencies regarding Transportation policy for non-MCP covered services and were addressed in APL 17-010.
C1XII.11a	**As of the end of this reporting period, have these deficiencies been resolved for all plans?**	Yes
C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other	Yes

	than MCO should have a single state summary parity analysis report.States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	
C1XII.12b	**Provide the URL link(s).** Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.	https://www.dhcs.ca.gov/formsandpubs/Pages/MentalHealthParity.aspx#:~:text=Parity%20compliance%20requires%20that%20the,prescription%20drugs%2C%20and%20emergency%20services.

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).	**Positive Health Care** 910 **Alameda Alliance for Health** 401,471 **Anthem Blue Cross Partnership Health Plan** 825,253 **Blue Shield of California Promise Health Plan** 195,725 **CalOptima Health** 902,875 **CalViva Health** 436,615 **CenCal Health** 241,518 **Central California Alliance for Health** 450,223 **Community Health Group Partnership Plan** 402,911 **Community Health Plan of Imperial Valley** 97,397 **Contra Costa Health Plan** 260,713 **Gold Coast Health Plan** 248,647 **Health Net Community Solutions, Inc.** 1,590,108 **Health Plan of San Joaquin** 423,712 **Health Plan of San Mateo**

146,353

Inland Empire Health Plan

1,495,956

Kaiser Foundation Health Plan, Inc.

1,118,657

Kern Family Health Care

406,049

L.A. Care Health Plan

2,363,545

Molina Healthcare of California

589,044

Partnership HealthPlan of California

907,764

San Francisco Health Plan

176,167

Santa Clara Family Health Plan

293,043

SCAN Health Plan

19,376

D1I.2

Plan share of Medicaid

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)

Positive Health Care

0%

Alameda Alliance for Health

2.7%

Anthem Blue Cross Partnership Health Plan

5.5%

Blue Shield of California Promise Health Plan

1.3%

CalOptima Health

6%

CalViva Health

2.9%

CenCal Health

1.6%

Central California Alliance for Health

3%

Community Health Group Partnership Plan

2.7%

Community Health Plan of Imperial Valley

0.7%

Contra Costa Health Plan

1.7%

Gold Coast Health Plan

1.7%

Health Net Community Solutions, Inc.

10.6%

Health Plan of San Joaquin

2.8%

Health Plan of San Mateo

1%

Inland Empire Health Plan

10%

Kaiser Foundation Health Plan, Inc.

7.5%

Kern Family Health Care

2.7%

L.A. Care Health Plan

15.8%

Molina Healthcare of California

3.9%

Partnership HealthPlan of California

6.1%

San Francisco Health Plan

1.2%

Santa Clara Family Health Plan

		2% **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 enrollment in any type of managed care?Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Positive Health Care** 0% **Alameda Alliance for Health** 2.9% **Anthem Blue Cross Partnership Health Plan** 5.9% **Blue Shield of California Promise Health Plan** 1.4% **CalOptima Health** 6.4% **CalViva Health** 3.1% **CenCal Health** 1.7% **Central California Alliance for Health** 3.2% **Community Health Group Partnership Plan** 2.9% **Community Health Plan of Imperial Valley** 0.7% **Contra Costa Health Plan** 1.9% **Gold Coast Health Plan** 1.8% **Health Net Community Solutions, Inc.** 11.4% **Health Plan of San Joaquin** 3%

Health Plan of San Mateo

1%

Inland Empire Health Plan

10.7%

Kaiser Foundation Health Plan, Inc.

8%

Kern Family Health Care

2.9%

L.A. Care Health Plan

16.9%

Molina Healthcare of California

4.2%

Partnership HealthPlan of California

6.5%

San Francisco Health Plan

1.3%

Santa Clara Family Health Plan

2.1%

SCAN Health Plan

0.1%

D1I.4: Parent

Organization: The name of the parent entity that controls the Medicaid Managed Care Plan.

If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.

Positive Health Care

NR

Alameda Alliance for Health

NR

Anthem Blue Cross Partnership Health Plan

NR

Blue Shield of California Promise Health Plan

NR

CalOptima Health

NR

CalViva Health

NR

CenCal Health

NR

Central California Alliance for Health

NR

Community Health Group Partnership Plan

NR

Community Health Plan of Imperial Valley

NR

Contra Costa Health Plan

NR

Gold Coast Health Plan

NR

Health Net Community Solutions, Inc.

NR

Health Plan of San Joaquin

NR

Health Plan of San Mateo

NR

Inland Empire Health Plan

NR

Kaiser Foundation Health Plan, Inc.

NR

Kern Family Health Care

NR

L.A. Care Health Plan

NR

Molina Healthcare of California

NR

Partnership HealthPlan of California

NR

San Francisco Health Plan

NR

Santa Clara Family Health Plan

NR

SCAN Health Plan

NR

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.	**Positive Health Care** 78.69% **Alameda Alliance for Health** 90.16% **Anthem Blue Cross Partnership Health Plan** 83.2% **Blue Shield of California Promise Health Plan** 86.42% **CalOptima Health** 82.82% **CalViva Health** 93.35% **CenCal Health** 91.19% **Central California Alliance for Health** 85.3% **Community Health Group Partnership Plan** 82.07% **Community Health Plan of Imperial Valley** NR **Contra Costa Health Plan** 86.55% **Gold Coast Health Plan** 79.05% **Health Net Community Solutions, Inc.** 83.8% **Health Plan of San Joaquin** 84.07% **Health Plan of San Mateo** 77.23% **Inland Empire Health Plan**

88.11%

Kaiser Foundation Health Plan, Inc.

105.35%

Kern Family Health Care

85.39%

L.A. Care Health Plan

90.8%

Molina Healthcare of California

79.84%

Partnership HealthPlan of California

86.4%

San Francisco Health Plan

83.12%

Santa Clara Family Health Plan

94.02%

SCAN Health Plan

88.08%

D1II.1b

Level of aggregation

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.

Positive Health Care

Statewide all programs & populations

Alameda Alliance for Health

Statewide all programs & populations

Anthem Blue Cross Partnership Health Plan

Statewide all programs & populations

Blue Shield of California Promise Health Plan

Statewide all programs & populations

CalOptima Health

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 Partnership Plan

Statewide all programs & populations

Community Health Plan of Imperial Valley

Other, specify – No data was entered for Community Health Plan of Imperial Valley because it was not an operating MCP during the CY 22 MLR reporting period.

Contra Costa Health Plan

Statewide all programs & populations

Gold Coast Health Plan

Statewide all programs & populations

Health Net Community Solutions, Inc.

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 Foundation Health Plan, Inc.

Statewide all programs & populations

Kern Family Health Care

Statewide all programs & populations

L.A. Care Health Plan

Statewide all programs & populations

Molina Healthcare of California

Statewide all programs & populations

Partnership HealthPlan 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 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.

Positive Health Care

N/A

Alameda Alliance for Health

N/A

Anthem Blue Cross Partnership Health Plan

Yes. For rating period CY 2022, 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 Health Plan

Yes. For rating period CY 2022, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

CalOptima Health

Yes. For rating period CY 2022, 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

NA

CenCal Health

N/A

Central California Alliance for Health

N/A

Community Health Group Partnership Plan

Yes. For rating period CY 2022, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

Community Health Plan of Imperial Valley

No data was entered for Community Health Plan of Imperial Valley because it was not an operating MCP during the CY 22 MLR reporting period.

Contra Costa Health Plan

N/A

Gold Coast Health Plan

N/A

Health Net Community Solutions, Inc.

Yes. For rating period CY 2022, 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 2022, 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 2022, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

Kaiser Foundation Health Plan, Inc.

Yes. For rating period CY 2022, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

Kern Family Health Care

N/A

L.A. Care Health Plan

Yes. For rating period CY 2022, 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 2022, the State requires a separate MLR for its MLTSS population. The state is still working with CMS on prior period MLTSS/CMC MLRs.

Partnership HealthPlan of California

N/A

San Francisco Health Plan

N/A

Santa Clara Family Health Plan

Yes. For rating period CY 2022, 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?

Positive Health Care

Yes

Alameda Alliance for Health

Yes

Anthem Blue Cross Partnership Health Plan

Yes

Blue Shield of California Promise Health Plan

Yes

CalOptima Health

Yes

CalViva Health

Yes

CenCal Health

Yes

Central California Alliance for Health

Yes

Community Health Group Partnership Plan

Yes

Community Health Plan of Imperial Valley

No

Contra Costa Health Plan

Yes

Gold Coast Health Plan

Yes

Health Net Community Solutions, Inc.

Yes

Health Plan of San Joaquin

Yes

Health Plan of San Mateo

Yes

Inland Empire Health Plan

Yes

Kaiser Foundation Health Plan, Inc.

Yes

Kern Family Health Care

Yes

L.A. Care Health Plan

Yes

		Molina Healthcare of California Yes **Partnership HealthPlan of California** Yes **San Francisco Health Plan** Yes **Santa Clara Family Health Plan** Yes **SCAN Health Plan** Yes
N/A	Enter the start date.	**Positive Health Care** 01/01/2022 **Alameda Alliance for Health** 01/01/2022 **Anthem Blue Cross Partnership Health Plan** 01/01/2022 **Blue Shield of California Promise Health Plan** 01/01/2022 **CalOptima Health** 01/01/2022 **CalViva Health** 01/01/2022 **CenCal Health** 01/01/2022 **Central California Alliance for Health** 01/01/2022 **Community Health Group Partnership Plan** 01/01/2022 **Community Health Plan of Imperial Valley**

		Not applicable **Contra Costa Health Plan** 01/01/2022 **Gold Coast Health Plan** 01/01/2022 **Health Net Community Solutions, Inc.** 01/01/2022 **Health Plan of San Joaquin** 01/01/2022 **Health Plan of San Mateo** 01/01/2022 **Inland Empire Health Plan** 01/01/2022 **Kaiser Foundation Health Plan, Inc.** 01/01/2022 **Kern Family Health Care** 01/01/2022 **L.A. Care Health Plan** 01/01/2022 **Molina Healthcare of California** 01/01/2022 **Partnership HealthPlan of California** 01/01/2022 **San Francisco Health Plan** 01/01/2022 **Santa Clara Family Health Plan** 01/01/2022 **SCAN Health Plan** 01/01/2022
N/A	Enter the end date.	**Positive Health Care** 12/31/2022 **Alameda Alliance for Health** 12/31/2022

Anthem Blue Cross Partnership Health Plan

12/31/2022

Blue Shield of California Promise Health Plan

12/31/2022

CalOptima Health

12/31/2022

CalViva Health

12/31/2022

CenCal Health

12/31/2022

Central California Alliance for Health

12/31/2022

Community Health Group Partnership Plan

12/31/2022

Community Health Plan of Imperial Valley

Not applicable

Contra Costa Health Plan

12/31/2022

Gold Coast Health Plan

12/31/2022

Health Net Community Solutions, Inc.

12/31/2022

Health Plan of San Joaquin

12/31/2022

Health Plan of San Mateo

12/31/2022

Inland Empire Health Plan

12/31/2022

Kaiser Foundation Health Plan, Inc.

12/31/2022

Kern Family Health Care

12/31/2022

L.A. Care Health Plan

12/31/2022

Molina Healthcare of California

12/31/2022

Partnership HealthPlan of California

12/31/2022

San Francisco Health Plan

12/31/2022

Santa Clara Family Health Plan

12/31/2022

SCAN Health Plan

12/31/2022

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.	**Positive Health Care** In January 1,2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS. **Alameda Alliance for Health** In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS. **Anthem Blue Cross Partnership Health Plan** In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS. **Blue Shield of California Promise Health Plan** In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the

quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

CalOptima Health

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

CalViva Health

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

CenCal Health

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition

of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Central California Alliance for Health

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Community Health Group Partnership Plan

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Community Health Plan of Imperial Valley

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Contra Costa Health Plan

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED)

Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Gold Coast Health Plan

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Health Net Community Solutions, Inc.

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Health Plan of San Joaquin

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission

Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Health Plan of San Mateo

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Inland Empire Health Plan

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Kaiser Foundation Health Plan, Inc.

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Kern Family Health Care

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

L.A. Care Health Plan

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Molina Healthcare of California

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Partnership HealthPlan of California

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the

encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

San Francisco Health Plan

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

Santa Clara Family Health Plan

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

SCAN Health Plan

In January 1, 2015, DHCS established the Quality Measures for Encounter Data (QMED) Report Card (per APL14-020) to assess the quality of encounter data submitted to DHCS PACES. QMED Measures define Timeliness. Data is timely when the span of time (Lag) between the Date of Service (DOS) of the encounter, and the date when the encounter data is submitted to DHCS (the Submission Date per response file). To meet the definition of Timeliness, the Managed Care Plan must submit at least 95% of encounters within 365 days of the DOS.

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.	**Positive Health Care** 99% **Alameda Alliance for Health** 100% **Anthem Blue Cross Partnership Health Plan** 97% **Blue Shield of California Promise Health Plan** 97% **CalOptima Health** 94% **CalViva Health** 98% **CenCal Health** 96% **Central California Alliance for Health** 99% **Community Health Group Partnership Plan** 99% **Community Health Plan of Imperial Valley** 100% **Contra Costa Health Plan** 99% **Gold Coast Health Plan** 98% **Health Net Community Solutions, Inc.** 96% **Health Plan of San Joaquin** 97% **Health Plan of San Mateo** 97% **Inland Empire Health Plan** 98%

Kaiser Foundation Health Plan, Inc.

100%

Kern Family Health Care

100%

L.A. Care Health Plan

94%

Molina Healthcare of California

99%

Partnership HealthPlan of California

59%

San Francisco Health Plan

95%

Santa Clara Family Health Plan

99%

SCAN Health Plan

70%

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.	**Positive Health Care** 100% **Alameda Alliance for Health** 100% **Anthem Blue Cross Partnership Health Plan** 100% **Blue Shield of California Promise Health Plan** 100% **CalOptima Health** 100% **CalViva Health** 100% **CenCal Health** 100% **Central California Alliance for Health** 100%

Community Health Group Partnership Plan

100%

Community Health Plan of Imperial Valley

100%

Contra Costa Health Plan

100%

Gold Coast Health Plan

100%

Health Net Community Solutions, Inc.

100%

Health Plan of San Joaquin

100%

Health Plan of San Mateo

100%

Inland Empire Health Plan

100%

Kaiser Foundation Health Plan, Inc.

100%

Kern Family Health Care

100%

L.A. Care Health Plan

100%

Molina Healthcare of California

100%

Partnership HealthPlan of California

100%

San Francisco Health Plan

100%

Santa Clara Family Health Plan

100%

SCAN Health Plan

100%

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.	**Positive Health Care** 1 **Alameda Alliance for Health** 512 **Anthem Blue Cross Partnership Health Plan** 414 **Blue Shield of California Promise Health Plan** 227 **CalOptima Health** 1,313 **CalViva Health** 431 **CenCal Health** 24 **Central California Alliance for Health** 226 **Community Health Group Partnership Plan** 111 **Community Health Plan of Imperial Valley** 50 **Contra Costa Health Plan** 231 **Gold Coast Health Plan** 72 **Health Net Community Solutions, Inc.** 1,130 **Health Plan of San Joaquin** 175 **Health Plan of San Mateo** 113 **Inland Empire Health Plan**

1,672

Kaiser Foundation Health Plan, Inc.

613

Kern Family Health Care

1,332

L.A. Care Health Plan

1,816

Molina Healthcare of California

642

Partnership HealthPlan of California

1,189

San Francisco Health Plan

90

Santa Clara Family Health Plan

123

SCAN Health Plan

4

D1IV.1a

Appeals denied

Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.

Positive Health Care

0

Alameda Alliance for Health

384

Anthem Blue Cross Partnership Health Plan

356

Blue Shield of California Promise Health Plan

145

CalOptima Health

742

CalViva Health

163

CenCal Health

12

Central California Alliance for Health

173

Community Health Group Partnership Plan

68

Community Health Plan of Imperial Valley

20

Contra Costa Health Plan

93

Gold Coast Health Plan

26

Health Net Community Solutions, Inc.

635

Health Plan of San Joaquin

80

Health Plan of San Mateo

59

Inland Empire Health Plan

1,153

Kaiser Foundation Health Plan, Inc.

429

Kern Family Health Care

756

L.A. Care Health Plan

1,283

Molina Healthcare of California

480

Partnership HealthPlan of California

961

San Francisco Health Plan

47

Santa Clara Family Health Plan

92

SCAN Health Plan

0

D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.	**Positive Health Care** 0 **Alameda Alliance for Health** 0 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 8 **CalOptima Health** 214 **CalViva Health** 18 **CenCal Health** 0 **Central California Alliance for Health** 3 **Community Health Group Partnership Plan** 0 **Community Health Plan of Imperial Valley** 1 **Contra Costa Health Plan** 0 **Gold Coast Health Plan** 8 **Health Net Community Solutions, Inc.** 55 **Health Plan of San Joaquin** 24 **Health Plan of San Mateo** 4 **Inland Empire Health Plan** 0

		Kaiser Foundation Health Plan, Inc. 5 **Kern Family Health Care** 15 **L.A. Care Health Plan** 322 **Molina Healthcare of California** 0 **Partnership HealthPlan of California** 64 **San Francisco Health Plan** 11 **Santa Clara Family Health Plan** 0 **SCAN Health Plan** 0
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.	**Positive Health Care** 1 **Alameda Alliance for Health** 114 **Anthem Blue Cross Partnership Health Plan** 54 **Blue Shield of California Promise Health Plan** 74 **CalOptima Health** 218 **CalViva Health** 250 **CenCal Health** 12 **Central California Alliance for Health** 49

		Community Health Group Partnership Plan 43 **Community Health Plan of Imperial Valley** 29 **Contra Costa Health Plan** 138 **Gold Coast Health Plan** 37 **Health Net Community Solutions, Inc.** 438 **Health Plan of San Joaquin** 71 **Health Plan of San Mateo** 50 **Inland Empire Health Plan** 301 **Kaiser Foundation Health Plan, Inc.** 179 **Kern Family Health Care** 561 **L.A. Care Health Plan** 161 **Molina Healthcare of California** 158 **Partnership HealthPlan of California** 140 **San Francisco Health Plan** 32 **Santa Clara Family Health Plan** 31 **SCAN Health Plan** 4
D1IV.2	**Active appeals**	**Positive Health Care**

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

0

Alameda Alliance for Health

60

Anthem Blue Cross Partnership Health Plan

74

Blue Shield of California Promise Health Plan

25

CalOptima Health

55

CalViva Health

51

CenCal Health

67

Central California Alliance for Health

38

Community Health Group Partnership Plan

8

Community Health Plan of Imperial Valley

10

Contra Costa Health Plan

4

Gold Coast Health Plan

27

Health Net Community Solutions, Inc.

166

Health Plan of San Joaquin

2

Health Plan of San Mateo

10

Inland Empire Health Plan

143

Kaiser Foundation Health Plan, Inc.

139

Kern Family Health Care

55

L.A. Care Health Plan

211

Molina Healthcare of California

34

Partnership HealthPlan of California

234

San Francisco Health Plan

24

Santa Clara Family Health Plan

90

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 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).

Positive Health Care

0

Alameda Alliance for Health

44

Anthem Blue Cross Partnership Health Plan

0

Blue Shield of California Promise Health Plan

19

CalOptima Health

38

CalViva Health

2

CenCal Health

1

Central California Alliance for Health

5

Community Health Group Partnership Plan

1

Community Health Plan of Imperial Valley

1

Contra Costa Health Plan

0

Gold Coast Health Plan

14

Health Net Community Solutions, Inc.

19

Health Plan of San Joaquin

0

Health Plan of San Mateo

1

Inland Empire Health Plan

10

Kaiser Foundation Health Plan, Inc.

0

Kern Family Health Care

6

L.A. Care Health Plan

72

Molina Healthcare of California

33

Partnership HealthPlan of California

39

San Francisco Health Plan

4

Santa Clara Family Health Plan

1

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**	**Positive Health Care** 0 **Alameda Alliance for Health**

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 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 Partnership Health Plan

0

Blue Shield of California Promise Health Plan

1

CalOptima Health

0

CalViva Health

5

CenCal Health

0

Central California Alliance for Health

0

Community Health Group Partnership Plan

0

Community Health Plan of Imperial Valley

2

Contra Costa Health Plan

0

Gold Coast Health Plan

0

Health Net Community Solutions, Inc.

12

Health Plan of San Joaquin

0

Health Plan of San Mateo

3

Inland Empire Health Plan

1

Kaiser Foundation Health Plan, Inc.

0

Kern Family Health Care

0

L.A. Care Health Plan

1

Molina Healthcare of California

0

Partnership HealthPlan of California

0

San Francisco Health Plan

0

Santa Clara Family Health Plan

1

SCAN Health Plan

0

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.

Positive Health Care

1

Alameda Alliance for Health

498

Anthem Blue Cross Partnership Health Plan

388

Blue Shield of California Promise Health Plan

163

CalOptima Health

1,091

CalViva Health

408

CenCal Health

20

Central California Alliance for Health

210

Community Health Group Partnership Plan

107

Community Health Plan of Imperial Valley

44

Contra Costa Health Plan

197

Gold Coast Health Plan

56

Health Net Community Solutions, Inc.

1,041

Health Plan of San Joaquin

152

Health Plan of San Mateo

88

Inland Empire Health Plan

1,528

Kaiser Foundation Health Plan, Inc.

480

Kern Family Health Care

1,234

L.A. Care Health Plan

1,493

Molina Healthcare of California

617

Partnership HealthPlan of California

1,145

San Francisco Health Plan

74

Santa Clara Family Health Plan

78

SCAN Health Plan

4

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

Positive Health Care

0

Alameda Alliance for Health

11

Anthem Blue Cross Partnership Health Plan

timely resolution of standard appeals.

22

Blue Shield of California Promise Health Plan

64

CalOptima Health

104

CalViva Health

23

CenCal Health

4

Central California Alliance for Health

5

Community Health Group Partnership Plan

3

Community Health Plan of Imperial Valley

6

Contra Costa Health Plan

34

Gold Coast Health Plan

12

Health Net Community Solutions, Inc.

87

Health Plan of San Joaquin

22

Health Plan of San Mateo

18

Inland Empire Health Plan

141

Kaiser Foundation Health Plan, Inc.

78

Kern Family Health Care

88

L.A. Care Health Plan

161

		Molina Healthcare of California 25 **Partnership HealthPlan of California** 18 **San Francisco Health Plan** 5 **Santa Clara Family Health Plan** 34 **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).	**Positive Health Care** 1 **Alameda Alliance for Health** 512 **Anthem Blue Cross Partnership Health Plan** 414 **Blue Shield of California Promise Health Plan** 179 **CalOptima Health** 1,305 **CalViva Health** 430 **CenCal Health** 24 **Central California Alliance for Health** 226 **Community Health Group Partnership Plan** 111 **Community Health Plan of Imperial Valley** 50 **Contra Costa Health Plan** 231

		Gold Coast Health Plan 72 **Health Net Community Solutions, Inc.** 1,026 **Health Plan of San Joaquin** 4 **Health Plan of San Mateo** 113 **Inland Empire Health Plan** 1,672 **Kaiser Foundation Health Plan, Inc.** 612 **Kern Family Health Care** 1,332 **L.A. Care Health Plan** 1,626 **Molina Healthcare of California** 421 **Partnership HealthPlan of California** 869 **San Francisco Health Plan** 82 **Santa Clara Family Health Plan** 121 **SCAN Health Plan** 3
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.	**Positive Health Care** 0 **Alameda Alliance for Health** 0 **Anthem Blue Cross Partnership Health Plan** 0

Blue Shield of California Promise Health Plan

0

CalOptima Health

0

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

0

Community Health Group Partnership Plan

0

Community Health Plan of Imperial Valley

0

Contra Costa Health Plan

0

Gold Coast Health Plan

0

Health Net Community Solutions, Inc.

0

Health Plan of San Joaquin

1

Health Plan of San Mateo

0

Inland Empire Health Plan

0

Kaiser Foundation Health Plan, Inc.

0

Kern Family Health Care

0

L.A. Care Health Plan

0

Molina Healthcare of California

		1 **Partnership HealthPlan of California** 1 **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.	**Positive Health Care** 0 **Alameda Alliance for Health** 0 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 48 **CalOptima Health** 2 **CalViva Health** 1 **CenCal Health** 0 **Central California Alliance for Health** 0 **Community Health Group Partnership Plan** 0 **Community Health Plan of Imperial Valley** 0 **Contra Costa Health Plan** 0 **Gold Coast Health Plan**

0

Health Net Community Solutions, Inc.

95

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

0

Kaiser Foundation Health Plan, Inc.

9

Kern Family Health Care

0

L.A. Care Health Plan

46

Molina Healthcare of California

193

Partnership HealthPlan of California

204

San Francisco Health Plan

8

Santa Clara Family Health Plan

2

SCAN Health Plan

1

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).

Positive Health Care

0

Alameda Alliance for Health

0

Anthem Blue Cross Partnership Health Plan

0

Blue Shield of California Promise Health Plan

0

CalOptima Health

7

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

0

Community Health Group Partnership Plan

0

Community Health Plan of Imperial Valley

0

Contra Costa Health Plan

0

Gold Coast Health Plan

0

Health Net Community Solutions, Inc.

2

Health Plan of San Joaquin

17

Health Plan of San Mateo

0

Inland Empire Health Plan

0

Kaiser Foundation Health Plan, Inc.

2

Kern Family Health Care

0

L.A. Care Health Plan

134

Molina Healthcare of California

7

		Partnership HealthPlan of California 0 **San Francisco Health Plan** 0 **Santa Clara Family Health Plan** 0 **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.	**Positive Health Care** 0 **Alameda Alliance for Health** 0 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 0 **CalOptima Health** 1 **CalViva Health** 0 **CenCal Health** 0 **Central California Alliance for Health** 0 **Community Health Group Partnership Plan** 0 **Community Health Plan of Imperial Valley** 0 **Contra Costa Health Plan** 0 **Gold Coast Health Plan** 1

Health Net Community Solutions, Inc.

0

Health Plan of San Joaquin

171

Health Plan of San Mateo

0

Inland Empire Health Plan

1

Kaiser Foundation Health Plan, Inc.

36

Kern Family Health Care

0

L.A. Care Health Plan

0

Molina Healthcare of California

6

Partnership HealthPlan of California

0

San Francisco Health Plan

0

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).

Positive Health Care

N/A

Alameda Alliance for Health

0

Anthem Blue Cross Partnership Health Plan

N/A

Blue Shield of California Promise Health Plan

N/A

CalOptima Health

0

CalViva Health

N/A

CenCal Health

0

Central California Alliance for Health

0

Community Health Group Partnership Plan

N/A

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

0

Gold Coast Health Plan

0

Health Net Community Solutions, Inc.

N/A

Health Plan of San Joaquin

N/A

Health Plan of San Mateo

0

Inland Empire Health Plan

N/A

Kaiser Foundation Health Plan, Inc.

N/A

Kern Family Health Care

N/A

L.A. Care Health Plan

N/A

Molina Healthcare of California

N/A

Partnership HealthPlan of California

113

		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.	**Positive Health Care** 0 **Alameda Alliance for Health** 0 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 0 **CalOptima Health** 0 **CalViva Health** 0 **CenCal Health** 0 **Central California Alliance for Health** 0 **Community Health Group Partnership Plan** 0 **Community Health Plan of Imperial Valley** 0 **Contra Costa Health Plan** 0 **Gold Coast Health Plan** 0 **Health Net Community Solutions, Inc.** 7

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

0

Kaiser Foundation Health Plan, Inc.

0

Kern Family Health Care

0

L.A. Care Health Plan

12

Molina Healthcare of California

14

Partnership HealthPlan of California

2

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”.	**Positive Health Care** 0 **Alameda Alliance for Health** 26 **Anthem Blue Cross Partnership Health Plan** 31 **Blue Shield of California Promise Health Plan** 6 **CalOptima Health** 29 **CalViva Health** 21 **CenCal Health** 0 **Central California Alliance for Health** 8 **Community Health Group Partnership Plan** 8 **Community Health Plan of Imperial Valley** 5 **Contra Costa Health Plan** 18 **Gold Coast Health Plan** 0 **Health Net Community Solutions, Inc.** 109 **Health Plan of San Joaquin** 1 **Health Plan of San Mateo** 0 **Inland Empire Health Plan**

		0 **Kaiser Foundation Health Plan, Inc.** 2 **Kern Family Health Care** 26 **L.A. Care Health Plan** 115 **Molina Healthcare of California** 46 **Partnership HealthPlan of California** 278 **San Francisco Health Plan** 1 **Santa Clara Family Health Plan** 3 **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 not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). 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”.	**Positive Health Care** 1 **Alameda Alliance for Health** 393 **Anthem Blue Cross Partnership Health Plan** 298 **Blue Shield of California Promise Health Plan** 138 **CalOptima Health** 873 **CalViva Health** 335 **CenCal Health** 16 **Central California Alliance for Health**

55

Community Health Group Partnership Plan

34

Community Health Plan of Imperial Valley

34

Contra Costa Health Plan

155

Gold Coast Health Plan

38

Health Net Community Solutions, Inc.

714

Health Plan of San Joaquin

89

Health Plan of San Mateo

67

Inland Empire Health Plan

682

Kaiser Foundation Health Plan, Inc.

0

Kern Family Health Care

1,191

L.A. Care Health Plan

361

Molina Healthcare of California

219

Partnership HealthPlan of California

455

San Francisco Health Plan

58

Santa Clara Family Health Plan

110

SCAN Health Plan

0

D1IV.7c	**Resolved appeals related to inpatient behavioral health services** 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”.	**Positive Health Care** N/A **Alameda Alliance for Health** N/A **Anthem Blue Cross Partnership Health Plan** N/A **Blue Shield of California Promise Health Plan** N/A **CalOptima Health** N/A **CalViva Health** N/A **CenCal Health** N/A **Central California Alliance for Health** N/A **Community Health Group Partnership Plan** N/A **Community Health Plan of Imperial Valley** N/A **Contra Costa Health Plan** N/A **Gold Coast Health Plan** N/A **Health Net Community Solutions, Inc.** N/A **Health Plan of San Joaquin** N/A **Health Plan of San Mateo** N/A **Inland Empire Health Plan** N/A

		Kaiser Foundation Health Plan, Inc. N/A **Kern Family Health Care** N/A **L.A. Care Health Plan** N/A **Molina Healthcare of California** N/A **Partnership HealthPlan 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 managed care plan does not cover outpatient behavioral health services, enter “N/A”.	**Positive Health Care** 0 **Alameda Alliance for Health** 0 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 0 **CalOptima Health** 0 **CalViva Health** 0 **CenCal Health** 0 **Central California Alliance for Health** 0

Community Health Group Partnership Plan

0

Community Health Plan of Imperial Valley

0

Contra Costa Health Plan

0

Gold Coast Health Plan

0

Health Net Community Solutions, Inc.

0

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

0

Kaiser Foundation Health Plan, Inc.

0

Kern Family Health Care

0

L.A. Care Health Plan

0

Molina Healthcare of California

0

Partnership HealthPlan of California

0

San Francisco Health Plan

0

Santa Clara Family Health Plan

0

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”.

Positive Health Care

0

Alameda Alliance for Health

13

Anthem Blue Cross Partnership Health Plan

15

Blue Shield of California Promise Health Plan

3

CalOptima Health

42

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

3

Community Health Group Partnership Plan

0

Community Health Plan of Imperial Valley

0

Contra Costa Health Plan

10

Gold Coast Health Plan

1

Health Net Community Solutions, Inc.

3

Health Plan of San Joaquin

2

Health Plan of San Mateo

0

Inland Empire Health Plan

55

		Kaiser Foundation Health Plan, Inc. 5 **Kern Family Health Care** 22 **L.A. Care Health Plan** 6 **Molina Healthcare of California** 25 **Partnership HealthPlan of California** 8 **San Francisco Health Plan** 15 **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”.	**Positive Health Care** 0 **Alameda Alliance for Health** 38 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 19 **CalOptima Health** 26 **CalViva Health** 2 **CenCal Health** 1 **Central California Alliance for Health** 4

Community Health Group Partnership Plan

1

Community Health Plan of Imperial Valley

1

Contra Costa Health Plan

0

Gold Coast Health Plan

13

Health Net Community Solutions, Inc.

7

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

13

Kaiser Foundation Health Plan, Inc.

0

Kern Family Health Care

4

L.A. Care Health Plan

41

Molina Healthcare of California

10

Partnership HealthPlan of California

28

San Francisco Health Plan

1

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”.(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Positive Health Care** 0 **Alameda Alliance for Health** 1 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 0 **CalOptima Health** 12 **CalViva Health** 0 **CenCal Health** 0 **Central California Alliance for Health** 1 **Community Health Group Partnership Plan** 0 **Community Health Plan of Imperial Valley** 0 **Contra Costa Health Plan** 0 **Gold Coast Health Plan** 0 **Health Net Community Solutions, Inc.** 10 **Health Plan of San Joaquin** 0 **Health Plan of San Mateo** 1 **Inland Empire Health Plan** 0

		Kaiser Foundation Health Plan, Inc. 0 **Kern Family Health Care** 2 **L.A. Care Health Plan** 33 **Molina Healthcare of California** 20 **Partnership HealthPlan of California** 0 **San Francisco Health Plan** 0 **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”.	**Positive Health Care** N/A **Alameda Alliance for Health** N/A **Anthem Blue Cross Partnership Health Plan** N/A **Blue Shield of California Promise Health Plan** N/A **CalOptima Health** N/A **CalViva Health** N/A **CenCal Health** N/A **Central California Alliance for Health** N/A

Community Health Group Partnership Plan

N/A

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

N/A

Gold Coast Health Plan

N/A

Health Net Community Solutions, Inc.

N/A

Health Plan of San Joaquin

N/A

Health Plan of San Mateo

8

Inland Empire Health Plan

N/A

Kaiser Foundation Health Plan, Inc.

N/A

Kern Family Health Care

N/A

L.A. Care Health Plan

N/A

Molina Healthcare of California

N/A

Partnership HealthPlan 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”.	**Positive Health Care** 0 **Alameda Alliance for Health** 0 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 0 **CalOptima Health** 3 **CalViva Health** 1 **CenCal Health** 0 **Central California Alliance for Health** 0 **Community Health Group Partnership Plan** 0 **Community Health Plan of Imperial Valley** 0 **Contra Costa Health Plan** 6 **Gold Coast Health Plan** 0 **Health Net Community Solutions, Inc.** 3 **Health Plan of San Joaquin** 0 **Health Plan of San Mateo** 1 **Inland Empire Health Plan** 1

Kaiser Foundation Health Plan, Inc.

11

Kern Family Health Care

0

L.A. Care Health Plan

0

Molina Healthcare of California

0

Partnership HealthPlan of California

8

San Francisco Health Plan

0

Santa Clara Family Health Plan

1

SCAN Health Plan

0

D1IV.7k:

Resolved appeals related to durable medical equipment (DME) & supplies

Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter “N/A”.

Positive Health Care

NR

Alameda Alliance for Health

NR

Anthem Blue Cross Partnership Health Plan

NR

Blue Shield of California Promise Health Plan

NR

CalOptima Health

NR

CalViva Health

NR

CenCal Health

NR

Central California Alliance for Health

NR

Community Health Group Partnership Plan

NR

Community Health Plan of Imperial Valley

NR

Contra Costa Health Plan

NR

Gold Coast Health Plan

NR

Health Net Community Solutions, Inc.

NR

Health Plan of San Joaquin

NR

Health Plan of San Mateo

NR

Inland Empire Health Plan

NR

Kaiser Foundation Health Plan, Inc.

NR

Kern Family Health Care

NR

L.A. Care Health Plan

NR

Molina Healthcare of California

NR

Partnership HealthPlan of California

NR

San Francisco Health Plan

NR

Santa Clara Family Health Plan

NR

SCAN Health Plan

NR

D1IV.7l:	**Resolved appeals related to home health / hospice** Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter “N/A”.	**Positive Health Care** NR **Alameda Alliance for Health** NR **Anthem Blue Cross Partnership Health Plan** NR **Blue Shield of California Promise Health Plan** NR **CalOptima Health** NR **CalViva Health** NR **CenCal Health** NR **Central California Alliance for Health** NR **Community Health Group Partnership Plan** NR **Community Health Plan of Imperial Valley** NR **Contra Costa Health Plan** NR **Gold Coast Health Plan** NR **Health Net Community Solutions, Inc.** NR **Health Plan of San Joaquin** NR **Health Plan of San Mateo** NR **Inland Empire Health Plan** NR

		Kaiser Foundation Health Plan, Inc. NR **Kern Family Health Care** NR **L.A. Care Health Plan** NR **Molina Healthcare of California** NR **Partnership HealthPlan of California** NR **San Francisco Health Plan** NR **Santa Clara Family Health Plan** NR **SCAN Health Plan** NR
D1IV.7m:	**Resolved appeals related to emergency services / emergency department** Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter “N/A”.	**Positive Health Care** NR **Alameda Alliance for Health** NR **Anthem Blue Cross Partnership Health Plan** NR **Blue Shield of California Promise Health Plan** NR **CalOptima Health** NR **CalViva Health** NR **CenCal Health** NR **Central California Alliance for Health** NR

Community Health Group Partnership Plan

NR

Community Health Plan of Imperial Valley

NR

Contra Costa Health Plan

NR

Gold Coast Health Plan

NR

Health Net Community Solutions, Inc.

NR

Health Plan of San Joaquin

NR

Health Plan of San Mateo

NR

Inland Empire Health Plan

NR

Kaiser Foundation Health Plan, Inc.

NR

Kern Family Health Care

NR

L.A. Care Health Plan

NR

Molina Healthcare of California

NR

Partnership HealthPlan of California

NR

San Francisco Health Plan

NR

Santa Clara Family Health Plan

NR

SCAN Health Plan

NR

D1IV.7n:

Resolved appeals related to therapies

Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.

Positive Health Care

NR

Alameda Alliance for Health

NR

Anthem Blue Cross Partnership Health Plan

NR

Blue Shield of California Promise Health Plan

NR

CalOptima Health

NR

CalViva Health

NR

CenCal Health

NR

Central California Alliance for Health

NR

Community Health Group Partnership Plan

NR

Community Health Plan of Imperial Valley

NR

Contra Costa Health Plan

NR

Gold Coast Health Plan

NR

Health Net Community Solutions, Inc.

NR

Health Plan of San Joaquin

NR

Health Plan of San Mateo

NR

Inland Empire Health Plan

NR

		Kaiser Foundation Health Plan, Inc. NR **Kern Family Health Care** NR **L.A. Care Health Plan** NR **Molina Healthcare of California** NR **Partnership HealthPlan of California** NR **San Francisco Health Plan** NR **Santa Clara Family Health Plan** NR **SCAN Health Plan** NR
D1IV.7o	**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-n paid primarily by Medicaid, enter “N/A”.	**Positive Health Care** 0 **Alameda Alliance for Health** 41 **Anthem Blue Cross Partnership Health Plan** 70 **Blue Shield of California Promise Health Plan** 61 **CalOptima Health** 328 **CalViva Health** 72 **CenCal Health** 7 **Central California Alliance for Health** 155

Community Health Group Partnership Plan

68

Community Health Plan of Imperial Valley

10

Contra Costa Health Plan

42

Gold Coast Health Plan

15

Health Net Community Solutions, Inc.

284

Health Plan of San Joaquin

83

Health Plan of San Mateo

36

Inland Empire Health Plan

921

Kaiser Foundation Health Plan, Inc.

595

Kern Family Health Care

87

L.A. Care Health Plan

1,260

Molina Healthcare of California

322

Partnership HealthPlan of California

412

San Francisco Health Plan

15

Santa Clara Family Health Plan

9

SCAN Health Plan

4

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	**Positive Health Care** 0 **Alameda Alliance for Health** 60 **Anthem Blue Cross Partnership Health Plan** 162 **Blue Shield of California Promise Health Plan** 25 **CalOptima Health** 180 **CalViva Health** 43 **CenCal Health** 15 **Central California Alliance for Health** 29 **Community Health Group Partnership Plan** 37 **Community Health Plan of Imperial Valley** 16 **Contra Costa Health Plan** 50 **Gold Coast Health Plan** 41 **Health Net Community Solutions, Inc.** 295 **Health Plan of San Joaquin** 99 **Health Plan of San Mateo** 15 **Inland Empire Health Plan**

128

Kaiser Foundation Health Plan, Inc.

106

Kern Family Health Care

47

L.A. Care Health Plan

411

Molina Healthcare of California

62

Partnership HealthPlan of California

271

San Francisco Health Plan

3

Santa Clara Family Health Plan

6

SCAN Health Plan

0

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.

Positive Health Care

0

Alameda Alliance for Health

1

Anthem Blue Cross Partnership Health Plan

4

Blue Shield of California Promise Health Plan

0

CalOptima Health

11

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

2

Community Health Group Partnership Plan

1

Community Health Plan of Imperial Valley

0

Contra Costa Health Plan

3

Gold Coast Health Plan

4

Health Net Community Solutions, Inc.

14

Health Plan of San Joaquin

2

Health Plan of San Mateo

1

Inland Empire Health Plan

6

Kaiser Foundation Health Plan, Inc.

1

Kern Family Health Care

3

L.A. Care Health Plan

21

Molina Healthcare of California

3

Partnership HealthPlan of California

20

San Francisco Health Plan

0

Santa Clara Family Health Plan

0

SCAN Health Plan

0

D1IV.8c

State Fair Hearings resulting in an adverse decision for the enrollee

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

Positive Health Care

0

Alameda Alliance for Health

40

Anthem Blue Cross Partnership Health Plan

67

Blue Shield of California Promise Health Plan

12

CalOptima Health

58

CalViva Health

10

CenCal Health

4

Central California Alliance for Health

11

Community Health Group Partnership Plan

12

Community Health Plan of Imperial Valley

8

Contra Costa Health Plan

32

Gold Coast Health Plan

14

Health Net Community Solutions, Inc.

139

Health Plan of San Joaquin

19

Health Plan of San Mateo

5

Inland Empire Health Plan

66

		Kaiser Foundation Health Plan, Inc. 49 **Kern Family Health Care** 13 **L.A. Care Health Plan** 209 **Molina Healthcare of California** 26 **Partnership HealthPlan of California** 103 **San Francisco Health Plan** 0 **Santa Clara Family Health Plan** 0 **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 reporting year prior to reaching a decision.	**Positive Health Care** 0 **Alameda Alliance for Health** 14 **Anthem Blue Cross Partnership Health Plan** 55 **Blue Shield of California Promise Health Plan** 5 **CalOptima Health** 86 **CalViva Health** 28 **CenCal Health** 9 **Central California Alliance for Health** 11

Community Health Group Partnership Plan

17

Community Health Plan of Imperial Valley

6

Contra Costa Health Plan

7

Gold Coast Health Plan

12

Health Net Community Solutions, Inc.

90

Health Plan of San Joaquin

67

Health Plan of San Mateo

7

Inland Empire Health Plan

42

Kaiser Foundation Health Plan, Inc.

31

Kern Family Health Care

26

L.A. Care Health Plan

113

Molina Healthcare of California

20

Partnership HealthPlan of California

101

San Francisco Health Plan

3

Santa Clara Family Health Plan

6

SCAN Health Plan

0

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".External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Positive Health Care** 0 **Alameda Alliance for Health** 2 **Anthem Blue Cross Partnership Health Plan** 7 **Blue Shield of California Promise Health Plan** 2 **CalOptima Health** 0 **CalViva Health** 1 **CenCal Health** 0 **Central California Alliance for Health** 0 **Community Health Group Partnership Plan** 1 **Community Health Plan of Imperial Valley** 0 **Contra Costa Health Plan** 2 **Gold Coast Health Plan** 0 **Health Net Community Solutions, Inc.** 11 **Health Plan of San Joaquin** 2 **Health Plan of San Mateo** 2 **Inland Empire Health Plan** 17

		Kaiser Foundation Health Plan, Inc. 10 **Kern Family Health Care** 11 **L.A. Care Health Plan** 10 **Molina Healthcare of California** 5 **Partnership HealthPlan of California** 0 **San Francisco Health Plan** 1 **Santa Clara Family Health Plan** 2 **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 CFR §438.402(c)(i)(B).	**Positive Health Care** 0 **Alameda Alliance for Health** 1 **Anthem Blue Cross Partnership Health Plan** 10 **Blue Shield of California Promise Health Plan** 4 **CalOptima Health** 0 **CalViva Health** 1 **CenCal Health** 0 **Central California Alliance for Health** 0

Community Health Group Partnership Plan

1

Community Health Plan of Imperial Valley

2

Contra Costa Health Plan

1

Gold Coast Health Plan

0

Health Net Community Solutions, Inc.

14

Health Plan of San Joaquin

1

Health Plan of San Mateo

0

Inland Empire Health Plan

31

Kaiser Foundation Health Plan, Inc.

39

Kern Family Health Care

8

L.A. Care Health Plan

11

Molina Healthcare of California

3

Partnership HealthPlan of California

0

San Francisco Health Plan

2

Santa Clara Family Health Plan

3

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 that were related to access to care.A grievance is “resolved” when it has reached completion and been closed by the plan.	**Positive Health Care** 179 **Alameda Alliance for Health** 36,011 **Anthem Blue Cross Partnership Health Plan** 11,691 **Blue Shield of California Promise Health Plan** 3,802 **CalOptima Health** 20,956 **CalViva Health** 4,260 **CenCal Health** 899 **Central California Alliance for Health** 4,255 **Community Health Group Partnership Plan** 1,621 **Community Health Plan of Imperial Valley** 890 **Contra Costa Health Plan** 2,855 **Gold Coast Health Plan** 649 **Health Net Community Solutions, Inc.** 21,519 **Health Plan of San Joaquin** 3,546 **Health Plan of San Mateo** 942 **Inland Empire Health Plan**

122,503

Kaiser Foundation Health Plan, Inc.

53,098

Kern Family Health Care

11,851

L.A. Care Health Plan

45,882

Molina Healthcare of California

12,930

Partnership HealthPlan of California

6,791

San Francisco Health Plan

542

Santa Clara Family Health Plan

3,684

SCAN Health Plan

268

D1IV.11

Active grievances

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

Positive Health Care

17

Alameda Alliance for Health

1,347

Anthem Blue Cross Partnership Health Plan

1,684

Blue Shield of California Promise Health Plan

207

CalOptima Health

922

CalViva Health

123

CenCal Health

412

Central California Alliance for Health

226

Community Health Group Partnership Plan

52

Community Health Plan of Imperial Valley

29

Contra Costa Health Plan

90

Gold Coast Health Plan

268

Health Net Community Solutions, Inc.

1,513

Health Plan of San Joaquin

28

Health Plan of San Mateo

77

Inland Empire Health Plan

2,932

Kaiser Foundation Health Plan, Inc.

7,131

Kern Family Health Care

505

L.A. Care Health Plan

11,719

Molina Healthcare of California

471

Partnership HealthPlan of California

305

San Francisco Health Plan

394

Santa Clara Family Health Plan

733

SCAN Health Plan

100

D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the 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.	**Positive Health Care** 5 **Alameda Alliance for Health** 96 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 77 **CalOptima Health** 78 **CalViva Health** 0 **CenCal Health** 3 **Central California Alliance for Health** 53 **Community Health Group Partnership Plan** 73 **Community Health Plan of Imperial Valley** 0 **Contra Costa Health Plan** 10 **Gold Coast Health Plan** 11 **Health Net Community Solutions, Inc.** 14 **Health Plan of San Joaquin** 19 **Health Plan of San Mateo** 11 **Inland Empire Health Plan** 298

		Kaiser Foundation Health Plan, Inc. 0 **Kern Family Health Care** 69 **L.A. Care Health Plan** 466 **Molina Healthcare of California** 33 **Partnership HealthPlan of California** 28 **San Francisco Health Plan** 8 **Santa Clara Family Health Plan** 16 **SCAN Health Plan** 4
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 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	**Positive Health Care** 0 **Alameda Alliance for Health** 0 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 6 **CalOptima Health** 0 **CalViva Health** 39 **CenCal Health** 0 **Central California Alliance for Health** 3

(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.

Community Health Group Partnership Plan

0

Community Health Plan of Imperial Valley

8

Contra Costa Health Plan

1

Gold Coast Health Plan

0

Health Net Community Solutions, Inc.

211

Health Plan of San Joaquin

5

Health Plan of San Mateo

9

Inland Empire Health Plan

23

Kaiser Foundation Health Plan, Inc.

0

Kern Family Health Care

2

L.A. Care Health Plan

25

Molina Healthcare of California

0

Partnership HealthPlan of California

5

San Francisco Health Plan

0

Santa Clara Family Health Plan

1

SCAN Health Plan

44

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.

Positive Health Care

175

Alameda Alliance for Health

35,970

Anthem Blue Cross Partnership Health Plan

11,125

Blue Shield of California Promise Health Plan

3,698

CalOptima Health

20,901

CalViva Health

4,258

CenCal Health

899

Central California Alliance for Health

4,244

Community Health Group Partnership Plan

1,621

Community Health Plan of Imperial Valley

890

Contra Costa Health Plan

2,797

Gold Coast Health Plan

573

Health Net Community Solutions, Inc.

21,505

Health Plan of San Joaquin

3,539

Health Plan of San Mateo

934

Inland Empire Health Plan

120,442

Kaiser Foundation Health Plan, Inc.

51,036

Kern Family Health Care

10,999

L.A. Care Health Plan

44,945

Molina Healthcare of California

12,908

Partnership HealthPlan of California

6,661

San Francisco Health Plan

504

Santa Clara Family Health Plan

3,635

SCAN Health Plan

268

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".	**Positive Health Care** 0 **Alameda Alliance for Health** 52 **Anthem Blue Cross Partnership Health Plan** 1 **Blue Shield of California Promise Health Plan** 40 **CalOptima Health** 144 **CalViva Health** 26 **CenCal Health** 3 **Central California Alliance for Health** 133 **Community Health Group Partnership Plan** 34 **Community Health Plan of Imperial Valley** 1 **Contra Costa Health Plan** 27 **Gold Coast Health Plan** 9 **Health Net Community Solutions, Inc.** 145 **Health Plan of San Joaquin** 41 **Health Plan of San Mateo** 11 **Inland Empire Health Plan**

536

Kaiser Foundation Health Plan, Inc.

301

Kern Family Health Care

65

L.A. Care Health Plan

3,208

Molina Healthcare of California

52

Partnership HealthPlan of California

35

San Francisco Health Plan

7

Santa Clara Family Health Plan

43

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 not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). 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”.

Positive Health Care

90

Alameda Alliance for Health

19,528

Anthem Blue Cross Partnership Health Plan

11

Blue Shield of California Promise Health Plan

1,764

CalOptima Health

11,618

CalViva Health

2,301

CenCal Health

759

Central California Alliance for Health

1,679

Community Health Group Partnership Plan

892

Community Health Plan of Imperial Valley

451

Contra Costa Health Plan

1,578

Gold Coast Health Plan

393

Health Net Community Solutions, Inc.

8,683

Health Plan of San Joaquin

2,006

Health Plan of San Mateo

395

Inland Empire Health Plan

23,219

Kaiser Foundation Health Plan, Inc.

0

Kern Family Health Care

9,385

L.A. Care Health Plan

9,470

Molina Healthcare of California

491

Partnership HealthPlan of California

2,294

San Francisco Health Plan

262

Santa Clara Family Health Plan

2,704

SCAN Health Plan

0

D1IV.15c	**Resolved grievances related to inpatient behavioral health services** 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".	**Positive Health Care** N/A **Alameda Alliance for Health** N/A **Anthem Blue Cross Partnership Health Plan** N/A **Blue Shield of California Promise Health Plan** N/A **CalOptima Health** N/A **CalViva Health** N/A **CenCal Health** N/A **Central California Alliance for Health** N/A **Community Health Group Partnership Plan** N/A **Community Health Plan of Imperial Valley** N/A **Contra Costa Health Plan** N/A **Gold Coast Health Plan** N/A **Health Net Community Solutions, Inc.** N/A **Health Plan of San Joaquin** N/A **Health Plan of San Mateo** N/A **Inland Empire Health Plan** N/A

		Kaiser Foundation Health Plan, Inc. N/A **Kern Family Health Care** N/A **L.A. Care Health Plan** N/A **Molina Healthcare of California** N/A **Partnership HealthPlan 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 managed care plan does not cover this type of service, enter "N/A".	**Positive Health Care** 0 **Alameda Alliance for Health** 0 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 0 **CalOptima Health** 0 **CalViva Health** 0 **CenCal Health** 0 **Central California Alliance for Health** 0

Community Health Group Partnership Plan

0

Community Health Plan of Imperial Valley

0

Contra Costa Health Plan

0

Gold Coast Health Plan

0

Health Net Community Solutions, Inc.

0

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

0

Kaiser Foundation Health Plan, Inc.

0

Kern Family Health Care

0

L.A. Care Health Plan

0

Molina Healthcare of California

0

Partnership HealthPlan of California

0

San Francisco Health Plan

0

Santa Clara Family Health Plan

0

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".

Positive Health Care

13

Alameda Alliance for Health

233

Anthem Blue Cross Partnership Health Plan

0

Blue Shield of California Promise Health Plan

64

CalOptima Health

114

CalViva Health

44

CenCal Health

3

Central California Alliance for Health

81

Community Health Group Partnership Plan

1

Community Health Plan of Imperial Valley

5

Contra Costa Health Plan

30

Gold Coast Health Plan

2

Health Net Community Solutions, Inc.

192

Health Plan of San Joaquin

11

Health Plan of San Mateo

5

Inland Empire Health Plan

146

		Kaiser Foundation Health Plan, Inc. 4,009 **Kern Family Health Care** 56 **L.A. Care Health Plan** 187 **Molina Healthcare of California** 205 **Partnership HealthPlan of California** 22 **San Francisco Health Plan** 22 **Santa Clara Family Health Plan** 5 **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”.	**Positive Health Care** 4 **Alameda Alliance for Health** 82 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 73 **CalOptima Health** 47 **CalViva Health** 0 **CenCal Health** 0 **Central California Alliance for Health** 29

Community Health Group Partnership Plan

70

Community Health Plan of Imperial Valley

0

Contra Costa Health Plan

14

Gold Coast Health Plan

8

Health Net Community Solutions, Inc.

11

Health Plan of San Joaquin

20

Health Plan of San Mateo

11

Inland Empire Health Plan

271

Kaiser Foundation Health Plan, Inc.

0

Kern Family Health Care

58

L.A. Care Health Plan

337

Molina Healthcare of California

16

Partnership HealthPlan of California

22

San Francisco Health Plan

6

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”.	**Positive Health Care** 0 **Alameda Alliance for Health** 6 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 0 **CalOptima Health** 30 **CalViva Health** 0 **CenCal Health** 0 **Central California Alliance for Health** 24 **Community Health Group Partnership Plan** 1 **Community Health Plan of Imperial Valley** 0 **Contra Costa Health Plan** 0 **Gold Coast Health Plan** 2 **Health Net Community Solutions, Inc.** 6 **Health Plan of San Joaquin** 0 **Health Plan of San Mateo** 1 **Inland Empire Health Plan** 5

		Kaiser Foundation Health Plan, Inc. 0 **Kern Family Health Care** 5 **L.A. Care Health Plan** 59 **Molina Healthcare of California** 22 **Partnership HealthPlan of California** 5 **San Francisco Health Plan** 1 **Santa Clara Family Health Plan** 8 **SCAN Health Plan** 2
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”.	**Positive Health Care** N/A **Alameda Alliance for Health** N/A **Anthem Blue Cross Partnership Health Plan** N/A **Blue Shield of California Promise Health Plan** N/A **CalOptima Health** N/A **CalViva Health** N/A **CenCal Health** N/A **Central California Alliance for Health** N/A

Community Health Group Partnership Plan

N/A

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

N/A

Gold Coast Health Plan

N/A

Health Net Community Solutions, Inc.

N/A

Health Plan of San Joaquin

N/A

Health Plan of San Mateo

130

Inland Empire Health Plan

N/A

Kaiser Foundation Health Plan, Inc.

N/A

Kern Family Health Care

N/A

L.A. Care Health Plan

N/A

Molina Healthcare of California

N/A

Partnership HealthPlan 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".	**Positive Health Care** 16 **Alameda Alliance for Health** 292 **Anthem Blue Cross Partnership Health Plan** 0 **Blue Shield of California Promise Health Plan** 50 **CalOptima Health** 353 **CalViva Health** 353 **CenCal Health** 7 **Central California Alliance for Health** 75 **Community Health Group Partnership Plan** 35 **Community Health Plan of Imperial Valley** 110 **Contra Costa Health Plan** 35 **Gold Coast Health Plan** 59 **Health Net Community Solutions, Inc.** 1,770 **Health Plan of San Joaquin** 42 **Health Plan of San Mateo** 22 **Inland Empire Health Plan** 1,887

		Kaiser Foundation Health Plan, Inc. 144 **Kern Family Health Care** 199 **L.A. Care Health Plan** 1,664 **Molina Healthcare of California** 531 **Partnership HealthPlan of California** 262 **San Francisco Health Plan** 16 **Santa Clara Family Health Plan** 0 **SCAN Health Plan** 0
D1IV.15k	**Resolved grievances related to durable medical equipment (DME) & supplies** Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter “N/A”.	**Positive Health Care** NR **Alameda Alliance for Health** NR **Anthem Blue Cross Partnership Health Plan** NR **Blue Shield of California Promise Health Plan** NR **CalOptima Health** NR **CalViva Health** NR **CenCal Health** NR **Central California Alliance for Health** NR

Community Health Group Partnership Plan

NR

Community Health Plan of Imperial Valley

NR

Contra Costa Health Plan

NR

Gold Coast Health Plan

NR

Health Net Community Solutions, Inc.

NR

Health Plan of San Joaquin

NR

Health Plan of San Mateo

NR

Inland Empire Health Plan

NR

Kaiser Foundation Health Plan, Inc.

NR

Kern Family Health Care

NR

L.A. Care Health Plan

NR

Molina Healthcare of California

NR

Partnership HealthPlan of California

NR

San Francisco Health Plan

NR

Santa Clara Family Health Plan

NR

SCAN Health Plan

NR

D1IV.15l	**Resolved grievances related to home health / hospice** Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter “N/A”.	**Positive Health Care** NR **Alameda Alliance for Health** NR **Anthem Blue Cross Partnership Health Plan** NR **Blue Shield of California Promise Health Plan** NR **CalOptima Health** NR **CalViva Health** NR **CenCal Health** NR **Central California Alliance for Health** NR **Community Health Group Partnership Plan** NR **Community Health Plan of Imperial Valley** NR **Contra Costa Health Plan** NR **Gold Coast Health Plan** NR **Health Net Community Solutions, Inc.** NR **Health Plan of San Joaquin** NR **Health Plan of San Mateo** NR **Inland Empire Health Plan** NR

		Kaiser Foundation Health Plan, Inc. NR **Kern Family Health Care** NR **L.A. Care Health Plan** NR **Molina Healthcare of California** NR **Partnership HealthPlan of California** NR **San Francisco Health Plan** NR **Santa Clara Family Health Plan** NR **SCAN Health Plan** NR
D1IV.15m	**Resolved grievances related to emergency services / emergency department** Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.	**Positive Health Care** NR **Alameda Alliance for Health** NR **Anthem Blue Cross Partnership Health Plan** NR **Blue Shield of California Promise Health Plan** NR **CalOptima Health** NR **CalViva Health** NR **CenCal Health** NR **Central California Alliance for Health** NR

Community Health Group Partnership Plan

NR

Community Health Plan of Imperial Valley

NR

Contra Costa Health Plan

NR

Gold Coast Health Plan

NR

Health Net Community Solutions, Inc.

NR

Health Plan of San Joaquin

NR

Health Plan of San Mateo

NR

Inland Empire Health Plan

NR

Kaiser Foundation Health Plan, Inc.

NR

Kern Family Health Care

NR

L.A. Care Health Plan

NR

Molina Healthcare of California

NR

Partnership HealthPlan of California

NR

San Francisco Health Plan

NR

Santa Clara Family Health Plan

NR

SCAN Health Plan

NR

D1IV.15n	**Resolved grievances related to therapies** Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.	**Positive Health Care** NR **Alameda Alliance for Health** NR **Anthem Blue Cross Partnership Health Plan** NR **Blue Shield of California Promise Health Plan** NR **CalOptima Health** NR **CalViva Health** NR **CenCal Health** NR **Central California Alliance for Health** NR **Community Health Group Partnership Plan** NR **Community Health Plan of Imperial Valley** NR **Contra Costa Health Plan** NR **Gold Coast Health Plan** NR **Health Net Community Solutions, Inc.** NR **Health Plan of San Joaquin** NR **Health Plan of San Mateo** NR **Inland Empire Health Plan** NR

		Kaiser Foundation Health Plan, Inc. NR **Kern Family Health Care** NR **L.A. Care Health Plan** NR **Molina Healthcare of California** NR **Partnership HealthPlan of California** NR **San Francisco Health Plan** NR **Santa Clara Family Health Plan** NR **SCAN Health Plan** NR
D1IV.15o	**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-n paid primarily by Medicaid, enter “N/A”.	**Positive Health Care** 56 **Alameda Alliance for Health** 15,818 **Anthem Blue Cross Partnership Health Plan** 11,679 **Blue Shield of California Promise Health Plan** 1,811 **CalOptima Health** 8,650 **CalViva Health** 1,536 **CenCal Health** 127 **Central California Alliance for Health** 2,234

Community Health Group Partnership Plan

588

Community Health Plan of Imperial Valley

323

Contra Costa Health Plan

1,171

Gold Coast Health Plan

176

Health Net Community Solutions, Inc.

10,712

Health Plan of San Joaquin

1,426

Health Plan of San Mateo

367

Inland Empire Health Plan

96,439

Kaiser Foundation Health Plan, Inc.

48,644

Kern Family Health Care

2,083

L.A. Care Health Plan

30,957

Molina Healthcare of California

11,613

Partnership HealthPlan of California

4,151

San Francisco Health Plan

228

Santa Clara Family Health Plan

924

SCAN Health Plan

266

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.	**Positive Health Care** 46 **Alameda Alliance for Health** 7,801 **Anthem Blue Cross Partnership Health Plan** 1,437 **Blue Shield of California Promise Health Plan** 654 **CalOptima Health** 4,276 **CalViva Health** 752 **CenCal Health** 316 **Central California Alliance for Health** 1,314 **Community Health Group Partnership Plan** 752 **Community Health Plan of Imperial Valley** 158 **Contra Costa Health Plan** 769 **Gold Coast Health Plan** 47 **Health Net Community Solutions, Inc.** 4,105 **Health Plan of San Joaquin** 1,064 **Health Plan of San Mateo**

278

Inland Empire Health Plan

47,468

Kaiser Foundation Health Plan, Inc.

8,830

Kern Family Health Care

4,037

L.A. Care Health Plan

9,799

Molina Healthcare of California

2,435

Partnership HealthPlan of California

1,930

San Francisco Health Plan

108

Santa Clara Family Health Plan

870

SCAN Health Plan

18

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.

Positive Health Care

5

Alameda Alliance for Health

442

Anthem Blue Cross Partnership Health Plan

80

Blue Shield of California Promise Health Plan

36

CalOptima Health

119

CalViva Health

8

CenCal Health

0

Central California Alliance for Health

66

Community Health Group Partnership Plan

46

Community Health Plan of Imperial Valley

2

Contra Costa Health Plan

86

Gold Coast Health Plan

21

Health Net Community Solutions, Inc.

41

Health Plan of San Joaquin

47

Health Plan of San Mateo

19

Inland Empire Health Plan

711

Kaiser Foundation Health Plan, Inc.

28,953

Kern Family Health Care

39

L.A. Care Health Plan

584

Molina Healthcare of California

0

Partnership HealthPlan of California

741

San Francisco Health Plan

35

Santa Clara Family Health Plan

62

SCAN Health Plan

1

D1IV.16c

Resolved grievances related to network adequacy or access to care/services from plan or provider

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.

Positive Health Care

38

Alameda Alliance for Health

7,585

Anthem Blue Cross Partnership Health Plan

1,913

Blue Shield of California Promise Health Plan

1,091

CalOptima Health

4,807

CalViva Health

1,281

CenCal Health

459

Central California Alliance for Health

1,003

Community Health Group Partnership Plan

53

Community Health Plan of Imperial Valley

310

Contra Costa Health Plan

688

Gold Coast Health Plan

158

Health Net Community Solutions, Inc.

6,783

Health Plan of San Joaquin

1,438

Health Plan of San Mateo

128

Inland Empire Health Plan

40,759

Kaiser Foundation Health Plan, Inc.

6,985

Kern Family Health Care

2,592

L.A. Care Health Plan

15,021

Molina Healthcare of California

2,623

Partnership HealthPlan of California

1,417

San Francisco Health Plan

128

Santa Clara Family Health Plan

947

SCAN Health Plan

15

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

Positive Health Care

20

Alameda Alliance for Health

719

Anthem Blue Cross Partnership Health Plan

1,311

Blue Shield of California Promise Health Plan

49

CalOptima Health

1,467

CalViva Health

224

CenCal Health

50

Central California Alliance for Health

636

Community Health Group Partnership Plan

262

Community Health Plan of Imperial Valley

21

Contra Costa Health Plan

538

Gold Coast Health Plan

207

Health Net Community Solutions, Inc.

872

Health Plan of San Joaquin

1,654

Health Plan of San Mateo

49

Inland Empire Health Plan

7,366

Kaiser Foundation Health Plan, Inc.

3,671

Kern Family Health Care

2,274

L.A. Care Health Plan

1,117

Molina Healthcare of California

397

Partnership HealthPlan of California

149

San Francisco Health Plan

14

Santa Clara Family Health Plan

3

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

Positive Health Care

21

Alameda Alliance for Health

13,961

Anthem Blue Cross Partnership Health Plan

426

Blue Shield of California Promise Health Plan

62

CalOptima Health

1,645

CalViva Health

438

CenCal Health

48

Central California Alliance for Health

308

Community Health Group Partnership Plan

12

Community Health Plan of Imperial Valley

104

Contra Costa Health Plan

201

Gold Coast Health Plan

11

		Health Net Community Solutions, Inc. 1,878 **Health Plan of San Joaquin** 836 **Health Plan of San Mateo** 18 **Inland Empire Health Plan** 10,017 **Kaiser Foundation Health Plan, Inc.** 9,050 **Kern Family Health Care** 1,139 **L.A. Care Health Plan** 3,253 **Molina Healthcare of California** 1,521 **Partnership HealthPlan of California** 364 **San Francisco Health Plan** 34 **Santa Clara Family Health Plan** 334 **SCAN Health Plan** 2
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.	**Positive Health Care** 5 **Alameda Alliance for Health** 4,186 **Anthem Blue Cross Partnership Health Plan** 6,183 **Blue Shield of California Promise Health Plan**

379

CalOptima Health

975

CalViva Health

609

CenCal Health

3

Central California Alliance for Health

374

Community Health Group Partnership Plan

225

Community Health Plan of Imperial Valley

66

Contra Costa Health Plan

873

Gold Coast Health Plan

36

Health Net Community Solutions, Inc.

2,144

Health Plan of San Joaquin

62

Health Plan of San Mateo

92

Inland Empire Health Plan

190

Kaiser Foundation Health Plan, Inc.

98

Kern Family Health Care

87

L.A. Care Health Plan

12,511

Molina Healthcare of California

1,262

Partnership HealthPlan of California

75

San Francisco Health Plan

27

Santa Clara Family Health Plan

106

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.

Positive Health Care

0

Alameda Alliance for Health

69

Anthem Blue Cross Partnership Health Plan

104

Blue Shield of California Promise Health Plan

5

CalOptima Health

14

CalViva Health

5

CenCal Health

0

Central California Alliance for Health

6

Community Health Group Partnership Plan

1

Community Health Plan of Imperial Valley

2

Contra Costa Health Plan

2

Gold Coast Health Plan

2

Health Net Community Solutions, Inc.

42

Health Plan of San Joaquin

1

Health Plan of San Mateo

7

Inland Empire Health Plan

2

Kaiser Foundation Health Plan, Inc.

334

Kern Family Health Care

185

L.A. Care Health Plan

179

Molina Healthcare of California

68

Partnership HealthPlan of California

12

San Francisco Health Plan

2

Santa Clara Family Health Plan

21

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.

Positive Health Care

1

Alameda Alliance for Health

23

Anthem Blue Cross Partnership Health Plan

34

Blue Shield of California Promise Health Plan

24

CalOptima Health

11

CalViva Health

27

CenCal Health

0

Central California Alliance for Health

1

Community Health Group Partnership Plan

1

Community Health Plan of Imperial Valley

1

Contra Costa Health Plan

12

Gold Coast Health Plan

3

Health Net Community Solutions, Inc.

60

Health Plan of San Joaquin

5

Health Plan of San Mateo

5

Inland Empire Health Plan

42

Kaiser Foundation Health Plan, Inc.

174

Kern Family Health Care

111

L.A. Care Health Plan

43

Molina Healthcare of California

11

Partnership HealthPlan of California

38

San Francisco Health Plan

9

Santa Clara Family Health Plan

25

SCAN Health Plan

0

D1IV.16i

Resolved grievances related to lack of timely plan response to a prior authorization/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).

Positive Health Care

0

Alameda Alliance for Health

21

Anthem Blue Cross Partnership Health Plan

1

Blue Shield of California Promise Health Plan

5

CalOptima Health

22

CalViva Health

164

CenCal Health

0

Central California Alliance for Health

4

Community Health Group Partnership Plan

0

Community Health Plan of Imperial Valley

56

Contra Costa Health Plan

8

Gold Coast Health Plan

3

Health Net Community Solutions, Inc.

729

Health Plan of San Joaquin

3

Health Plan of San Mateo

2

Inland Empire Health Plan

36

Kaiser Foundation Health Plan, Inc.

1,226

Kern Family Health Care

0

L.A. Care Health Plan

6

Molina Healthcare of California

42

Partnership HealthPlan of California

4

San Francisco Health Plan

0

Santa Clara Family Health Plan

11

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.

Positive Health Care

0

Alameda Alliance for Health

1

Anthem Blue Cross Partnership Health Plan

2

Blue Shield of California Promise Health Plan

2

CalOptima Health

1

CalViva Health

0

CenCal Health

0

Central California Alliance for Health

0

Community Health Group Partnership Plan

0

Community Health Plan of Imperial Valley

0

Contra Costa Health Plan

3

Gold Coast Health Plan

0

Health Net Community Solutions, Inc.

0

Health Plan of San Joaquin

0

Health Plan of San Mateo

0

Inland Empire Health Plan

0

Kaiser Foundation Health Plan, Inc.

0

Kern Family Health Care

0

L.A. Care Health Plan

3

Molina Healthcare of California

1

Partnership HealthPlan of California

2

San Francisco Health Plan

0

Santa Clara Family Health Plan

2

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.

Positive Health Care

43

Alameda Alliance for Health

4,257

Anthem Blue Cross Partnership Health Plan

1,863

Blue Shield of California Promise Health Plan

1,495

CalOptima Health

7,662

CalViva Health

752

CenCal Health

23

Central California Alliance for Health

558

Community Health Group Partnership Plan

269

Community Health Plan of Imperial Valley

170

Contra Costa Health Plan

532

Gold Coast Health Plan

164

Health Net Community Solutions, Inc.

4,865

Health Plan of San Joaquin

839

Health Plan of San Mateo

353

Inland Empire Health Plan

16,071

Kaiser Foundation Health Plan, Inc.

9,971

Kern Family Health Care

1,393

L.A. Care Health Plan

10,470

Molina Healthcare of California

4,570

Partnership HealthPlan of California

2,117

San Francisco Health Plan

205

Santa Clara Family Health Plan

1,322

SCAN Health Plan

231

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: 18

Complete

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

1 / 18

D2.VII.2 Measure Domain

Child & Adolescent Preventative Health

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

0038

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 nine combination rates.

Measure results

Positive Health Care

N/A

Alameda Alliance for Health

45.74%

Anthem Blue Cross Partnership Health Plan

27.29%

Blue Shield of California Promise Health Plan

33.09%

CalOptima Health

36.50%

CalViva Health

29.24%

CenCal Health

38.25%

Central California Alliance for Health

36.58%

Community Health Group Partnership Plan

32.85%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

45.61%

Gold Coast Health Plan

32.85%

Health Net Community Solutions, Inc.

26.98%

Health Plan of San Joaquin

25.07%

Health Plan of San Mateo

54.03%

Inland Empire Health Plan

22.99%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 48.87% / SoCal 50.30%

Kern Family Health Care

24.82%

L.A. Care Health Plan

29.68%

Molina Healthcare of California

26.42%

Partnership HealthPlan of California

32.82%

San Francisco Health Plan

55.33%

Santa Clara Family Health Plan

42.82%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Developmental Screening in the First Three Years of Life (DEV)

D2.VII.2 Measure Domain

Child & Adolescent Preventative Health

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

1448

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.

Measure results

Positive Health Care

N/A

Alameda Alliance for Health

54.39%

Anthem Blue Cross Partnership Health Plan

26.78%

Blue Shield of California Promise Health Plan

49.45%

CalOptima Health

45.69%

CalViva Health

29.05%

CenCal Health

41.03%

Central California Alliance for Health

36.92%

Community Health Group Partnership Plan

53.43%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

56.90%

Gold Coast Health Plan

47.85%

Health Net Community Solutions, Inc.

32.88%

Health Plan of San Joaquin

22.57%

Health Plan of San Mateo

56.07%

Inland Empire Health Plan

53.44%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 60.11% & SoCal 79.88%

Kern Family Health Care

25.94%

L.A. Care Health Plan

39.68%

Molina Healthcare of California

48.11%

Partnership HealthPlan of California

30.03%

San Francisco Health Plan

54.82%

Santa Clara Family Health Plan

59.17%

SCAN Health Plan

N/A

Complete

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

D2.VII.2 Measure Domain

Child & Adolescent Preventative Health

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

1407

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

Positive Health Care

N/A

Alameda Alliance for Health

49.27%

Anthem Blue Cross Partnership Health Plan

35.70%

Blue Shield of California Promise Health Plan

42.82%

CalOptima Health

47.45%

CalViva Health

37.02%

CenCal Health

42.88%

Central California Alliance for Health

49.65%

Community Health Group Partnership Plan

45.01%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

55.56%

Gold Coast Health Plan

41.61%

Health Net Community Solutions, Inc.

36.64%

Health Plan of San Joaquin

37.15%

Health Plan of San Mateo

50.85%

Inland Empire Health Plan

37.96%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 65.63% & SoCal 57.36%

Kern Family Health Care

34.06%

L.A. Care Health Plan

44.28%

Molina Healthcare of California

34.76%

Partnership HealthPlan of California

42.67%

San Francisco Health Plan

55.50%

Santa Clara Family Health Plan

50.36%

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

Positive Health Care

N/A

Alameda Alliance for Health

61.31%

Anthem Blue Cross Partnership Health Plan

53.61%

Blue Shield of California Promise Health Plan

64.23%

CalOptima Health

63.89%

CalViva Health

59.24%

CenCal Health

67.29%

Central California Alliance for Health

67.36%

Community Health Group Partnership Plan

64.96%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

52.81%

Gold Coast Health Plan

69.87%

Health Net Community Solutions, Inc.

54.01%

Health Plan of San Joaquin

45.31%

Health Plan of San Mateo

70.66%

Inland Empire Health Plan

52.39%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 43.80% & SoCal 59.00%

Kern Family Health Care

58.64%

L.A. Care Health Plan

63.26%

Molina Healthcare of California

56.63%

Partnership HealthPlan of California

59.18%

San Francisco Health Plan

75.68%

Santa Clara Family Health Plan

63.00%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Topical Fluoride for Children—Dental or Oral Health Services (TFL-CH)

D2.VII.2 Measure Domain

Child & Adolescent Preventative Health

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

3700

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

Percentage of children aged 1–21 years who received at least 2 topical fluoride applications as (a) dental OR oral health services, (b) dental services, and (c) oral health services within the reporting year

Measure results

Positive Health Care

N/A

Alameda Alliance for Health

14.13%

Anthem Blue Cross Partnership Health Plan

13.21%

Blue Shield of California Promise Health Plan

17.65%

CalOptima Health

23.25%

CalViva Health

19.38%

CenCal Health

25.42%

Central California Alliance for Health

21.50%

Community Health Group Partnership Plan

20.22%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

15.21%

Gold Coast Health Plan

28.10%

Health Net Community Solutions, Inc.

18.33%

Health Plan of San Joaquin

18.93%

Health Plan of San Mateo

23.00%

Inland Empire Health Plan

19.35%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 13.92% & SoCal 20.39%

Kern Family Health Care

16.44%

L.A. Care Health Plan

20.77%

Molina Healthcare of California

17.94%

Partnership HealthPlan of California

0.25%

San Francisco Health Plan

17.77%

Santa Clara Family Health Plan

16.83%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits (W30-6+)

D2.VII.2 Measure Domain

Child & Adolescent Preventative Health

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

1392

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

Positive Health Care

N/A

Alameda Alliance for Health

58.67%

Anthem Blue Cross Partnership Health Plan

48.16%

Blue Shield of California Promise Health Plan

53.55%

CalOptima Health

58.92%

CalViva Health

57.29%

CenCal Health

63.07%

Central California Alliance for Health

62.54%

Community Health Group Partnership Plan

60.94%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

73.17%

Gold Coast Health Plan

60.70%

Health Net Community Solutions, Inc.

52.17%

Health Plan of San Joaquin

49.68%

Health Plan of San Mateo

58.58%

Inland Empire Health Plan

59.95%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 75.21% & SoCal 78.96%

Kern Family Health Care

39.21%

L.A. Care Health Plan

46.72%

Molina Healthcare of California

32.38%

Partnership HealthPlan of California

42.09%

San Francisco Health Plan

53.94%

Santa Clara Family Health Plan

56.34%

SCAN Health Plan

N/A

Complete

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

7 / 18

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

Positive Health Care

N/A

Alameda Alliance for Health

74.03%

Anthem Blue Cross Partnership Health Plan

63.04%

Blue Shield of California Promise Health Plan

67.02%

CalOptima Health

72.44%

CalViva Health

65.68%

CenCal Health

80.26%

Central California Alliance for Health

73.11%

Community Health Group Partnership Plan

66.77%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

75.59%

Gold Coast Health Plan

72.94%

Health Net Community Solutions, Inc.

62.05%

Health Plan of San Joaquin

62.54%

Health Plan of San Mateo

72.96%

Inland Empire Health Plan

67.15%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 76.43% & SoCal 80.10%

Kern Family Health Care

63.74%

L.A. Care Health Plan

64.28%

Molina Healthcare of California

61.24%

Partnership HealthPlan of California

64.55%

San Francisco Health Plan

72.73%

Santa Clara Family Health Plan

72.85%

SCAN Health Plan

N/A

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.

Measure results

Positive Health Care

N/A

Alameda Alliance for Health

56.30%

Anthem Blue Cross Partnership Health Plan

44.14%

Blue Shield of California Promise Health Plan

53.12%

CalOptima Health

53.03%

CalViva Health

52.32%

CenCal Health

58.00%

Central California Alliance for Health

59.95%

Community Health Group Partnership Plan

53.24%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

56.63%

Gold Coast Health Plan

49.80%

Health Net Community Solutions, Inc.

45.18%

Health Plan of San Joaquin

48.15%

Health Plan of San Mateo

54.81%

Inland Empire Health Plan

51.49%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 53.70% & SoCal 47.61%

Kern Family Health Care

46.55%

L.A. Care Health Plan

48.67%

Molina Healthcare of California

44.55%

Partnership HealthPlan of California

47.41%

San Francisco Health Plan

57.12%

Santa Clara Family Health Plan

53.49%

SCAN Health Plan

N/A

Complete

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

9 / 18

D2.VII.2 Measure Domain

Women's/Maternity Health

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

0033

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

Positive Health Care

N/A

Alameda Alliance for Health

67.14%

Anthem Blue Cross Partnership Health Plan

61.22%

Blue Shield of California Promise Health Plan

66.00%

CalOptima Health

72.26%

CalViva Health

61.68%

CenCal Health

63.83%

Central California Alliance for Health

59.35%

Community Health Group Partnership Plan

66.39%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

68.37%

Gold Coast Health Plan

63.59%

Health Net Community Solutions, Inc.

68.58%

Health Plan of San Joaquin

56.70%

Health Plan of San Mateo

69.07%

Inland Empire Health Plan

67.93%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 68.44% & SoCal 65.47%

Kern Family Health Care

56.87%

L.A. Care Health Plan

69.91%

Molina Healthcare of California

65.28%

Partnership HealthPlan of California

56.00%

San Francisco Health Plan

68.38%

Santa Clara Family Health Plan

65.82%

SCAN Health Plan

N/A

Complete

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

10 / 18

D2.VII.2 Measure Domain

Women's/Maternity Health

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

1517

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. Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery

Measure results

Positive Health Care

N/A

Alameda Alliance for Health

89.95%

Anthem Blue Cross Partnership Health Plan

78.66%

Blue Shield of California Promise Health Plan

83.41%

CalOptima Health

80.00%

CalViva Health

82.03%

CenCal Health

95.06%

Central California Alliance for Health

89.83%

Community Health Group Partnership Plan

78.54%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

89.94%

Gold Coast Health Plan

89.29%

Health Net Community Solutions, Inc.

78.74%

Health Plan of San Joaquin

85.17%

Health Plan of San Mateo

86.63%

Inland Empire Health Plan

81.72%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 81.32% & SoCal 82.24%

Kern Family Health Care

86.37%

L.A. Care Health Plan

82.59%

Molina Healthcare of California

78.37%

Partnership HealthPlan of California

88.14%

San Francisco Health Plan

91.28%

Santa Clara Family Health Plan

80.05%

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 Health

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

1517

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. 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.

Measure results

Positive Health Care

N/A

Alameda Alliance for Health

90.87%

Anthem Blue Cross Partnership Health Plan

84.76%

Blue Shield of California Promise Health Plan

84.28%

CalOptima Health

88.08%

CalViva Health

90.51%

CenCal Health

89.29%

Central California Alliance for Health

92.11%

Community Health Group Partnership Plan

84.61%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

93.08%

Gold Coast Health Plan

92.21%

Health Net Community Solutions, Inc.

85.95%

Health Plan of San Joaquin

85.96%

Health Plan of San Mateo

91.28%

Inland Empire Health Plan

86.74%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 90.29% & SoCal 93.28%

Kern Family Health Care

87.10%

L.A. Care Health Plan

91.11%

Molina Healthcare of California

81.52%

Partnership HealthPlan of California

88.92%

San Francisco Health Plan

84.88%

Santa Clara Family Health Plan

90.51%

SCAN Health Plan

N/A

Complete

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

12 / 18

D2.VII.2 Measure Domain

Women's/Maternity Health

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

2372

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

Positive Health Care

N/A

Alameda Alliance for Health

59.59%

Anthem Blue Cross Partnership Health Plan

46.91%

Blue Shield of California Promise Health Plan

56.12%

CalOptima Health

58.39%

CalViva Health

58.72%

CenCal Health

59.96%

Central California Alliance for Health

60.79%

Community Health Group Partnership Plan

62.21%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

63.81%

Gold Coast Health Plan

59.65%

Health Net Community Solutions, Inc.

53.96%

Health Plan of San Joaquin

51.35%

Health Plan of San Mateo

63.27%

Inland Empire Health Plan

62.39%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 78.72% & SoCal 75.09%

Kern Family Health Care

59.30%

L.A. Care Health Plan

59.61%

Molina Healthcare of California

51.75%

Partnership HealthPlan of California

55.52%

San Francisco Health Plan

62.67%

Santa Clara Family Health Plan

55.66%

SCAN Health Plan

N/A

Complete

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

13 / 18

D2.VII.2 Measure Domain

Women's/Maternity Health

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

0032

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

Positive Health Care

N/A

Alameda Alliance for Health

60.58%

Anthem Blue Cross Partnership Health Plan

51.18%

Blue Shield of California Promise Health Plan

56.34%

CalOptima Health

58.31%

CalViva Health

61.35%

CenCal Health

64.07%

Central California Alliance for Health

65.99%

Community Health Group Partnership Plan

59.85%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

68.61%

Gold Coast Health Plan

61.31%

Health Net Community Solutions, Inc.

55.22%

Health Plan of San Joaquin

60.99%

Health Plan of San Mateo

61.22%

Inland Empire Health Plan

65.93%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 72.39% & SoCal 74.48%

Kern Family Health Care

57.18%

L.A. Care Health Plan

55.99%

Molina Healthcare of California

48.60%

Partnership HealthPlan of California

58.04%

San Francisco Health Plan

60.05%

Santa Clara Family Health Plan

60.58%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio (AMR)

D2.VII.2 Measure Domain

Chronic Disease

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

1800

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 s adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Measure results

Positive Health Care

N/A

Alameda Alliance for Health

69.88%

Anthem Blue Cross Partnership Health Plan

64.63%

Blue Shield of California Promise Health Plan

67.05%

CalOptima Health

66.33%

CalViva Health

64.18%

CenCal Health

81.92%

Central California Alliance for Health

75.16%

Community Health Group Partnership Plan

72.87%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

83.22%

Gold Coast Health Plan

46.80%

Health Net Community Solutions, Inc.

57.56%

Health Plan of San Joaquin

64.48%

Health Plan of San Mateo

75.18%

Inland Empire Health Plan

64.98%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 79.12% & SoCal 83.13%

Kern Family Health Care

71.20%

L.A. Care Health Plan

62.99%

Molina Healthcare of California

58.68%

Partnership HealthPlan of California

64.01%

San Francisco Health Plan

66.27%

Santa Clara Family Health Plan

68.91%

SCAN Health Plan

N/A

Complete

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

15 / 18

D2.VII.2 Measure Domain

Chronic Disease

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

0018

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

Positive Health Care

N/A

Alameda Alliance for Health

65.21%

Anthem Blue Cross Partnership Health Plan

62.43%

Blue Shield of California Promise Health Plan

69.25%

CalOptima Health

76.33%

CalViva Health

65.64%

CenCal Health

62.93%

Central California Alliance for Health

64.67%

Community Health Group Partnership Plan

63.02%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

67.21%

Gold Coast Health Plan

62.29%

Health Net Community Solutions, Inc.

65.19%

Health Plan of San Joaquin

66.05%

Health Plan of San Mateo

71.58%

Inland Empire Health Plan

67.55%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 77.04% & SoCal 79.76%

Kern Family Health Care

65.21%

L.A. Care Health Plan

66.75%

Molina Healthcare of California

65.01%

Partnership HealthPlan of California

63.96%

San Francisco Health Plan

71.75%

Santa Clara Family Health Plan

60.58%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

16 / 18

D2.VII.2 Measure Domain

Chronic Disease

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

0059

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

Positive Health Care

N/A

Alameda Alliance for Health

30.37%

Anthem Blue Cross Partnership Health Plan

36.89%

Blue Shield of California Promise Health Plan

31.63%

CalOptima Health

29.34%

CalViva Health

34.04%

CenCal Health

30.87%

Central California Alliance for Health

29.52%

Community Health Group Partnership Plan

33.33%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

29.11%

Gold Coast Health Plan

28.71%

Health Net Community Solutions, Inc.

32.68%

Health Plan of San Joaquin

33.05%

Health Plan of San Mateo

30.77%

Inland Empire Health Plan

32.68%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 25.65% & SoCal 18.78%

Kern Family Health Care

32.85%

L.A. Care Health Plan

36.43%

Molina Healthcare of California

33.90%

Partnership HealthPlan of California

33.27%

San Francisco Health Plan

23.69%

Santa Clara Family Health Plan

27.01%

SCAN Health Plan

N/A

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

3489

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

Positive Health Care

N/A

Alameda Alliance for Health

54.69%

Anthem Blue Cross Partnership Health Plan

36.95%

Blue Shield of California Promise Health Plan

25.24%

CalOptima Health

35.73%

CalViva Health

17.55%

CenCal Health

44.43%

Central California Alliance for Health

41.04%

Community Health Group Partnership Plan

28.64%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

58.78%

Gold Coast Health Plan

23.59%

Health Net Community Solutions, Inc.

24.84%

Health Plan of San Joaquin

25.07%

Health Plan of San Mateo

64.43%

Inland Empire Health Plan

65.71%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 80.04% & SoCal 59.26%

Kern Family Health Care

19.12%

L.A. Care Health Plan

35.45%

Molina Healthcare of California

29.64%

Partnership HealthPlan of California

31.48%

San Francisco Health Plan

27.48%

Santa Clara Family Health Plan

56.02%

SCAN Health Plan

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After ED Visit for Substance Abuse - 30 days (FUA-30) 18 / 18

D2.VII.2 Measure Domain

Behavioral health care

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

2605

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

Positive Health Care

N/A

Alameda Alliance for Health

38.90%

Anthem Blue Cross Partnership Health Plan

27.85%

Blue Shield of California Promise Health Plan

30.82%

CalOptima Health

21.41%

CalViva Health

15.66%

CenCal Health

37.51%

Central California Alliance for Health

32.37%

Community Health Group Partnership Plan

28.85%

Community Health Plan of Imperial Valley

N/A

Contra Costa Health Plan

32.31%

Gold Coast Health Plan

28.32%

Health Net Community Solutions, Inc.

22.77%

Health Plan of San Joaquin

20.05%

Health Plan of San Mateo

49.13%

Inland Empire Health Plan

37.53%

Kaiser Foundation Health Plan, Inc.

Kaiser NorCal 39.12% & SoCal 46.77%

Kern Family Health Care

18.85%

L.A. Care Health Plan

28.40%

Molina Healthcare of California

32.49%

Partnership HealthPlan of California

32.02%

San Francisco Health Plan

21.74%

Santa Clara Family Health Plan

31.81%

SCAN Health Plan

N/A

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. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

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: 77

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

1 / 77

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Alameda Alliance for Health

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$37,000

D3.VIII.7 Date assessed

12/06/2024

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

2 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Anthem Blue Cross Partnership Health Plan

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

105

D3.VIII.6 Sanction amount

$819,000

D3.VIII.7 Date assessed

12/06/2024

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

3 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Blue Shield of California Promise Health Plan

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

CalViva Health

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

16

D3.VIII.6 Sanction amount

$67,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

CenCal Health

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

10

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Central California Alliance for Health

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Contra Costa Health Plan

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$57,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Health Net Community Solutions, Inc.

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

74

D3.VIII.6 Sanction amount

$519,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Network adequacy

D3.VIII.3 Plan name

Health Plan of San Joaquin

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

18

D3.VIII.6 Sanction amount

$68,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Inland Empire Health Plan

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$41,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Kaiser Foundation Health Plan, Inc.

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$60,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name

Performance Improvement

Kern Family Health Care

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

8

D3.VIII.6 Sanction amount

$49,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

L.A. Care Health Plan

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

$214,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Molina Healthcare of California

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

38

D3.VIII.6 Sanction amount

$247,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Partnership HealthPlan of California

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

32

D3.VIII.6 Sanction amount

$475,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

San Francisco Health Plan

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

12/06/2024

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 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Santa Clara Family Health Plan

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$26,000

D3.VIII.7 Date assessed

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

12/06/2024

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

18 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Health Net Community Solutions, Inc.

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

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

19 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Molina Healthcare of California

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

N/A

33

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

20 / 77

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Anthem Blue Cross Partnership Health Plan

D3.VIII.4 Reason for intervention

Poor quality performance measurement year 2023

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

21 / 77

D3.VIII.2 Plan performance issue

Time or Distance

D3.VIII.3 Plan name

Anthem Blue Cross Partnership Health Plan

D3.VIII.4 Reason for intervention

DHCS identified missing items and denials of Alternative Access Standard requests (AAS). DHCS 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

10/28/2024

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

Yes, remediated 01/03/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

22 / 77

D3.VIII.2 Plan performance issue

Time or Distance

D3.VIII.3 Plan name

Community Health Group Partnership Plan

D3.VIII.4 Reason for intervention

DHCS identified missing items and denials of Alternative Access Standard requests (AAS). DHCS 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

10/28/2024

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

Yes, remediated 01/21/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

23 / 77

D3.VIII.2 Plan performance issue

Time or Distance

D3.VIII.3 Plan name

Inland Empire Health Plan

D3.VIII.4 Reason for intervention

DHCS identified missing items and denials of Alternative Access Standard requests (AAS). DHCS 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

10/28/2024

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

Yes, remediated 01/03/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

24 / 77

D3.VIII.2 Plan performance issue

Time or Distance

D3.VIII.3 Plan name

L.A. Care Health Plan

D3.VIII.4 Reason for intervention

DHCS identified missing items and denials of Alternative Access Standard requests (AAS). DHCS 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

10/28/2024

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

Yes, remediated 01/03/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

25 / 77

D3.VIII.2 Plan performance issue

Time or Distance

D3.VIII.3 Plan name

Molina Healthcare of California

D3.VIII.4 Reason for intervention

DHCS identified missing items and denials of Alternative Access Standard requests (AAS). DHCS 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

10/28/2024

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

Yes, remediated 01/03/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

26 / 77

D3.VIII.2 Plan performance issue

• 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

Positive Health Care

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

N/A

11

D3.VIII.7 Date assessed

04/15/2024

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

27 / 77

D3.VIII.2 Plan performance issue

• Case Management and Coordination of Care

D3.VIII.3 Plan name

Positive Health Care

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/24/2024

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

28 / 77

D3.VIII.2 Plan performance issue

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

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

20

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

11/21/2024

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

29 / 77

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Alameda Alliance for Health

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

9

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/04/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Corrective action plan

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Complete

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Anthem Blue Cross Partnership Health Plan

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

11

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/17/2024

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

Yes, remediated 12/06/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Anthem Blue Cross Partnership Health Plan

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

13

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/05/2024

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

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D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Blue Shield of California Promise 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

09/20/2024

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

33 / 77

D3.VIII.2 Plan performance issue

• Access and Availability of Care

D3.VIII.3 Plan name

Blue Shield of California Promise Health Plan

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/06/2024

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

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D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

CalOptima Health

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

10

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

08/22/2024

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

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D3.VIII.2 Plan performance issue

• Case Management and Coordination of Care

D3.VIII.3 Plan name

CalOptima Health

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/06/2024

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

Yes, remediated 01/09/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

36 / 77

D3.VIII.2 Plan performance issue

• 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

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/03/2024

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 / 77

D3.VIII.2 Plan performance issue

• Case Management and Coordination of Care •

D3.VIII.3 Plan name

CalViva Health

Access and Availability of Care

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

9

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/06/2024

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

D3.VIII.2 Plan performance issue

• Access and Availability of Care

D3.VIII.3 Plan name

CenCal Health

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/06/2024

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 / 77

D3.VIII.2 Plan performance issue

• Access and Availability of Care • State Supported Services

D3.VIII.3 Plan name

Central California Alliance for Health

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

05/15/2024

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

Yes, remediated 08/20/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

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D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Central California Alliance for Health

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

8

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/05/2024

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

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D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Community Health Group Partnership Plan

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

11/06/2024

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

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D3.VIII.2 Plan performance issue

• Access and Availability of Care

D3.VIII.3 Plan name

Community Health Group Partnership Plan

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/06/2024

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

Yes, remediated 01/17/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

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D3.VIII.2 Plan performance issue

• 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

Contra Costa Health Plan

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

10

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/07/2024

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

Yes, remediated 09/13/2024

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Corrective action plan

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Complete

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Contra Costa Health Plan

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

9

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/09/2024

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

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D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Gold Coast Health Plan

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/06/2024

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

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D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Health Net Community Solutions, Inc.

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

7

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/06/2024

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

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D3.VIII.2 Plan performance issue

• Utilization Management • Case Management and Coordination of Care • Administrative and Organizational Capacity • State Supported Services

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

7

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

04/10/2024

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

Yes, remediated 12/05/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

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D3.VIII.2 Plan performance issue

• Access and Availability of Care

D3.VIII.3 Plan name

Health Plan of San Joaquin

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/09/2024

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

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D3.VIII.2 Plan performance issue

• Utilization Management • Case Management and

D3.VIII.3 Plan name

Health Plan of San Mateo

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

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

21

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/25/2024

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

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D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Health Plan of San Mateo

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

13

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/05/2025

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

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D3.VIII.2 Plan performance issue

• Utilization Management • Member's Rights

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

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/08/2024

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

Yes, remediated 06/12/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

52 / 77

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Inland Empire Health Plan

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

N/A

8

D3.VIII.7 Date assessed

09/04/2024

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

53 / 77

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Kaiser Foundation Health Plan, Inc.

D3.VIII.4 Reason for intervention

Annual Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

14

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/20/2024

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

Yes, remediated 12/13/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

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D3.VIII.2 Plan performance issue

• Case Management and Coordination of Care •

D3.VIII.3 Plan name

Kaiser Foundation Health Plan, Inc.

Access and Availability of Care

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

11

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/09/2024

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

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D3.VIII.2 Plan performance issue

• Administrative and Organizational Capacity

D3.VIII.3 Plan name

Kern Family Health Care

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

03/26/2024

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

Yes, remediated 06/05/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Kern Family Health Care

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

7

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/06/2024

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

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

L.A. Care Health Plan

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/06/2024

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

D3.VIII.2 Plan performance issue

• Utilization Management • Member's Rights

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

5

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

08/05/2024

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

Yes, remediated 01/24/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Molina Healthcare of California

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

12

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/05/2024

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

60 / 77

D3.VIII.2 Plan performance issue

• Member's Rights • Quality Management

D3.VIII.3 Plan name

Partnership HealthPlan of California

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

03/26/2024

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

Yes, remediated 12/06/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

61 / 77

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

Partnership HealthPlan of California

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

7

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/04/2024

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

62 / 77

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

San Francisco 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

08/02/2024

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

63 / 77

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

San Francisco Health Plan

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

9

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/09/2024

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

64 / 77

D3.VIII.2 Plan performance issue

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

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

9

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/28/2024

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

65 / 77

D3.VIII.2 Plan performance issue

• Case Management and Coordination of Care

D3.VIII.3 Plan name

Santa Clara Family Health Plan

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/06/2024

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

66 / 77

D3.VIII.2 Plan performance issue

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

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

6

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/25/2024

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

67 / 77

D3.VIII.2 Plan performance issue

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

D3.VIII.3 Plan name

SCAN Health Plan

D3.VIII.4 Reason for intervention

Focused Medical Audit

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/06/2024

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

68 / 77

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name

Contra Costa Health Plan

Untimely Data Submissions

D3.VIII.4 Reason for intervention

Contra Costa Health Plan had not been submitting timely data for rate setting and financials for years. They also ignored emails when they were past due.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/03/2024

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

Yes, remediated 02/25/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

69 / 77

D3.VIII.2 Plan performance issue

LTC ICF/DD Network Readiness Requirements

D3.VIII.3 Plan name

Inland Empire Health Plan

D3.VIII.4 Reason for intervention

DHCS has reviewed Inland Empire Health Plan's network readiness submission and determined Inland Empire Health Plan did not meet Phase I of the LTC ICF/DD Network Readiness Requirements for: • The requirement to contract with at least one (1) LTC ICF/DD home statewide. • The requirement to contract with at least one (1) LTC ICF/DD-H within the following service area(s): San Bernadino and Riverside • The requirement to contract with at least one (1) LTC ICF/DD-N within the following service area(s): San Bernadino and Riverside

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

04/02/2024

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

Yes, remediated 07/24/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

70 / 77

D3.VIII.2 Plan performance issue

Prompt Payment Standards

D3.VIII.3 Plan name

Anthem Blue Cross Partnership Health Plan

D3.VIII.4 Reason for intervention

Plan did not pay the following claims: o 2023 SNF Retroactive Payments

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/28/2024

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

Yes, remediated 09/25/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

71 / 77

D3.VIII.2 Plan performance issue

LTC ICF/DD Network Readiness Requirements

D3.VIII.3 Plan name

Alameda Alliance for Health

D3.VIII.4 Reason for intervention

DHCS reviewed Alameda Alliance for Health's network readiness submission and determined Alameda Alliance for Health did not meet Phase I of the LTC ICF/DD Network Readiness Requirements for: • The requirement to contract with at least one (1) LTC ICF/DD home statewide.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/01/2024

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

Yes, remediated 10/03/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

72 / 77

D3.VIII.2 Plan performance issue

Mental Health and Substance Use Disorder Parity compliance

D3.VIII.3 Plan name

Positive Health Care

D3.VIII.4 Reason for intervention

DHCS reviewed Postive Healthcare's network readiness submission and determined Posiitve Healthcare Foundation did not meet Phase I of the LTC ICF/DD Network Readiness Requirements for: • The requirement to contract with at least one (1) LTC ICF/DD home statewide.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/01/2024

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

Yes, remediated 10/03/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

73 / 77

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name

Contra Costa Health Plan

LTC ICF/DD Network
Readiness Requirements

D3.VIII.4 Reason for intervention

DHCS reviewed Contra Costa Health Plan's network readiness submission and determined Contra Costa Health Plan did not meet Phase I of the LTC ICF/DD Network Readiness Requirements for: • The requirement to contract with at least one (1) LTC ICF/DD home statewide.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/02/2024

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

Yes, remediated 10/03/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

74 / 77

D3.VIII.2 Plan performance issue

LTC ICF/DD Network
Readiness Requirements

D3.VIII.3 Plan name

Health Plan of San Joaquin

D3.VIII.4 Reason for intervention

DHCS Health Plan of San Joaquin's network readiness submission and determined Health Plan of San Joaquin did not meet Phase I of the LTC ICF/DD Network Readiness Requirements for: • The requirement to contract with at least one (1) LTC ICF/DD home statewide. • The requirement to contract with at least one (1) LTC ICF/DD-N within the following service area(s): Stanislaus County.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/01/2024

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

Yes, remediated 10/03/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

75 / 77

D3.VIII.2 Plan performance issue

LTC ICF/DD Network Readiness Requirements

D3.VIII.3 Plan name

Health Plan of San Mateo

D3.VIII.4 Reason for intervention

DHCS reviewed Health Plan of San Mateo's network readiness submission and determined Health Plan of San Mateo did not meet Phase I of the LTC ICF/DD Network Readiness Requirements for: • The requirement to contract with at least one (1) LTC ICF/DD home statewide.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/02/2024

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

Yes, remediated 10/03/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

76 / 77

D3.VIII.2 Plan performance issue

LTC ICF/DD Network Readiness Requirements

D3.VIII.3 Plan name

Kaiser Foundation Health Plan, Inc.

D3.VIII.4 Reason for intervention

DHCS reviewed Kaiser Foundation Health Plan's network readiness submission and determined Kaiser Foundation Health Plan did not meet Phase I of the LTC ICF/DD Network Readiness Requirements for: • The requirement to contract with at least one (1) LTC ICF/DD-H within the following service area(s): Imperial, Marin, Napa, Orange, Sacramento,

Sonoma, Tulare, and Yolo • The requirement to contract with at least one (1) LTC ICF/DD-N within the following service area(s): Fresno, Placer, Orange, San Diego, Sonoma, Sutter, Tulare, and Yolo.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/02/2024

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

Yes, remediated 10/03/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

77 / 77

D3.VIII.2 Plan performance issue

Post Stabilization Care Services, Timely Transfer to In-Network Provider

D3.VIII.3 Plan name

CalOptima Health

D3.VIII.4 Reason for intervention

CalOptima terminated its contract with Prime Hospitals in Orange County. Agency and DHCS received complaints from Prime pertaining to CalOptima's timely transfer of patients from the Prime Facilities to in-network providers/facilities. DHCS has been conducting daily monitoring of CalOptima members presenting at Prime facilities. DHCS conducted a series of cross-functional site visits to assess CalOptima for compliance with contractual requirements.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/09/2024

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

Remediation in progress

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).	**Positive Health Care** 3 **Alameda Alliance for Health** 18 **Anthem Blue Cross Partnership Health Plan** 23 **Blue Shield of California Promise Health Plan** 8 **CalOptima Health** 7 **CalViva Health** 5 **CenCal Health** 4 **Central California Alliance for Health** 6 **Community Health Group Partnership Plan** 9 **Community Health Plan of Imperial Valley** 6 **Contra Costa Health Plan** 8 **Gold Coast Health Plan** 22 **Health Net Community Solutions, Inc.** 3 **Health Plan of San Joaquin** 7 **Health Plan of San Mateo** 4 **Inland Empire Health Plan**

6

Kaiser Foundation Health Plan, Inc.

4

Kern Family Health Care

7

L.A. Care Health Plan

17

Molina Healthcare of California

137

Partnership HealthPlan of California

5

San Francisco Health Plan

83

Santa Clara Family Health Plan

14

SCAN Health Plan

4

D1X.2

Count of opened program integrity investigations

How many program integrity investigations were opened by the plan during the reporting year?

Positive Health Care

0

Alameda Alliance for Health

64

Anthem Blue Cross Partnership Health Plan

46

Blue Shield of California Promise Health Plan

256

CalOptima Health

79

CalViva Health

24

CenCal Health

92

Central California Alliance for Health

83

Community Health Group Partnership Plan

13

Community Health Plan of Imperial Valley

0

Contra Costa Health Plan

5

Gold Coast Health Plan

10

Health Net Community Solutions, Inc.

139

Health Plan of San Joaquin

42

Health Plan of San Mateo

40

Inland Empire Health Plan

370

Kaiser Foundation Health Plan, Inc.

170

Kern Family Health Care

298

L.A. Care Health Plan

467

Molina Healthcare of California

270

Partnership HealthPlan of California

69

San Francisco Health Plan

22

Santa Clara Family Health Plan

7

SCAN Health Plan

20

D1X.4

Count of resolved program integrity investigations

How many program integrity investigations were resolved by the plan during the reporting year?

Positive Health Care

0

Alameda Alliance for Health

5

Anthem Blue Cross Partnership Health Plan

17

Blue Shield of California Promise Health Plan

80

CalOptima Health

23

CalViva Health

4

CenCal Health

67

Central California Alliance for Health

56

Community Health Group Partnership Plan

5

Community Health Plan of Imperial Valley

0

Contra Costa Health Plan

2

Gold Coast Health Plan

3

Health Net Community Solutions, Inc.

52

Health Plan of San Joaquin

27

Health Plan of San Mateo

36

Inland Empire Health Plan

190

Kaiser Foundation Health Plan, Inc.

132

Kern Family Health Care

254

L.A. Care Health Plan

160

Molina Healthcare of California

151

Partnership HealthPlan of California

54

San Francisco Health Plan

12

Santa Clara Family Health Plan

4

SCAN Health Plan

1

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.	**Positive Health Care** Makes referrals to the State Medicaid Agency (SMA) only **Alameda Alliance for Health** Makes referrals to the State Medicaid Agency (SMA) only **Anthem Blue Cross Partnership Health Plan** Makes referrals to the State Medicaid Agency (SMA) only **Blue Shield of California Promise Health Plan** Makes referrals to the State Medicaid Agency (SMA) only **CalOptima Health** Makes referrals to the State Medicaid Agency (SMA) only **CalViva Health**

Makes referrals to the State Medicaid Agency (SMA) only

CenCal Health

Makes referrals to the State Medicaid Agency (SMA) only

Central California Alliance for Health

Makes referrals to the State Medicaid Agency (SMA) only

Community Health Group Partnership Plan

Makes referrals to the State Medicaid Agency (SMA) only

Community Health Plan of Imperial Valley

Makes referrals to the State Medicaid Agency (SMA) only

Contra Costa Health Plan

Makes referrals to the State Medicaid Agency (SMA) only

Gold Coast Health Plan

Makes referrals to the State Medicaid Agency (SMA) only

Health Net Community Solutions, Inc.

Makes referrals to the State Medicaid Agency (SMA) only

Health Plan of San Joaquin

Makes referrals to the State Medicaid Agency (SMA) only

Health Plan of San Mateo

Makes referrals to the State Medicaid Agency (SMA) only

Inland Empire Health Plan

Makes referrals to the State Medicaid Agency (SMA) only

Kaiser Foundation Health Plan, Inc.

Makes referrals to the State Medicaid Agency (SMA) only

Kern Family Health Care

Makes referrals to the State Medicaid Agency (SMA) only

L.A. Care Health Plan

Makes referrals to the State Medicaid Agency (SMA) only

Molina Healthcare of California

Makes referrals to the State Medicaid Agency (SMA) only

Partnership HealthPlan of California

Makes referrals to the State Medicaid Agency (SMA) only

San Francisco Health Plan

Makes referrals to the State Medicaid Agency (SMA) only

Santa Clara Family Health Plan

Makes referrals to the State Medicaid Agency (SMA) only

SCAN Health Plan

Makes referrals to the State Medicaid Agency (SMA) only

D1X.7

Count of program integrity referrals to the state

Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made.

Positive Health Care

0

Alameda Alliance for Health

64

Anthem Blue Cross Partnership Health Plan

46

Blue Shield of California Promise Health Plan

256

CalOptima Health

79

CalViva Health

24

CenCal Health

92

Central California Alliance for Health

83

Community Health Group Partnership Plan

13

Community Health Plan of Imperial Valley

0

Contra Costa Health Plan

5

Gold Coast Health Plan

10

Health Net Community Solutions, Inc.

139

Health Plan of San Joaquin

42

Health Plan of San Mateo

40

Inland Empire Health Plan

370

Kaiser Foundation Health Plan, Inc.

170

Kern Family Health Care

298

L.A. Care Health Plan

467

Molina Healthcare of California

270

Partnership HealthPlan of California

69

San Francisco Health Plan

22

Santa Clara Family Health Plan

7

SCAN Health Plan

20

D1X.9a:

Plan overpayment reporting to the state: Start Date

What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?

Positive Health Care

01/01/2023

Alameda Alliance for Health

07/01/2023

Anthem Blue Cross Partnership Health Plan

07/01/2023

Blue Shield of California Promise Health Plan

07/01/2023

CalOptima Health

07/01/2023

CalViva Health

07/01/2023

CenCal Health

07/01/2023

Central California Alliance for Health

07/01/2023

Community Health Group Partnership Plan

07/01/2023

Community Health Plan of Imperial Valley

07/01/2023

Contra Costa Health Plan

07/01/2023

Gold Coast Health Plan

07/01/2023

Health Net Community Solutions, Inc.

07/01/2023

Health Plan of San Joaquin

07/01/2023

Health Plan of San Mateo

07/01/2023

Inland Empire Health Plan

07/01/2023

Kaiser Foundation Health Plan, Inc.

07/01/2023

Kern Family Health Care

07/01/2023

L.A. Care Health Plan

07/01/2023

Molina Healthcare of California

07/01/2023

Partnership HealthPlan of California

07/01/2023

San Francisco Health Plan

07/01/2023

Santa Clara Family Health Plan

07/01/2023

SCAN Health Plan

01/01/2023

D1X.9b:

Plan overpayment reporting to the state: End Date

What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?

Positive Health Care

12/31/2023

Alameda Alliance for Health

06/30/2024

Anthem Blue Cross Partnership Health Plan

06/30/2024

Blue Shield of California Promise Health Plan

06/30/2024

CalOptima Health

06/30/2024

CalViva Health

06/30/2024

CenCal Health

06/30/2024

Central California Alliance for Health

06/30/2024

Community Health Group Partnership Plan

06/30/2024

Community Health Plan of Imperial Valley

06/30/2024

Contra Costa Health Plan

06/30/2024

Gold Coast Health Plan

06/30/2024

Health Net Community Solutions, Inc.

06/30/2024

Health Plan of San Joaquin

06/30/2024

Health Plan of San Mateo

06/30/2024

Inland Empire Health Plan

06/30/2024

Kaiser Foundation Health Plan, Inc.

06/30/2024

Kern Family Health Care

06/30/2024

L.A. Care Health Plan

06/30/2024

Molina Healthcare of California

06/30/2024

Partnership HealthPlan of California

06/30/2024

San Francisco Health Plan

06/30/2024

Santa Clara Family Health Plan

06/30/2024

SCAN Health Plan

12/31/2023

D1X.9c:

Plan overpayment reporting to the state: Dollar amount

From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?

Positive Health Care

$46,568

Alameda Alliance for Health

$654,369.47

Anthem Blue Cross Partnership Health Plan

$14,848,161.17

Blue Shield of California Promise Health Plan

$5,250,708

CalOptima Health

$10,106,904.77

CalViva Health

$21,134,870.18

CenCal Health

$4,970,198.51

Central California Alliance for Health

$31,352,376.14

Community Health Group Partnership Plan

$2,430,610.78

Community Health Plan of Imperial Valley

$1,418,904.39

Contra Costa Health Plan

$479,551.08

Gold Coast Health Plan

$940,988.04

Health Net Community Solutions, Inc.

$27,477,854.10

Health Plan of San Joaquin

$2,645,197.99

Health Plan of San Mateo

$6,861,302.87

Inland Empire Health Plan

$6,381,331.05

Kaiser Foundation Health Plan, Inc.

$6,003,421.98

Kern Family Health Care

$3,993,710.82

L.A. Care Health Plan

$67,971,335.27

Molina Healthcare of California

$13,467,334.21

Partnership HealthPlan of California

$20,033,751.63

San Francisco Health Plan

$205,490.49

Santa Clara Family Health Plan

$3,155,856.74

SCAN Health Plan

$0

D1X.9d:

Plan overpayment reporting to the state: Corresponding premium revenue

What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))

Positive Health Care

$11,934,094.61

Alameda Alliance for Health

$1,819,783,344

Anthem Blue Cross Partnership Health Plan

$3,390,380,003.99

Blue Shield of California Promise Health Plan

$880,504,801.90

CalOptima Health

$4,033,878,367.16

CalViva Health

$1,413,483,355.44

CenCal Health

$1,045,486,165.01

Central California Alliance for Health

$1,926,918,363.40

Community Health Group Partnership Plan

$1,691,310,599.32

Community Health Plan of Imperial Valley

$142,454,750.73

Contra Costa Health Plan

$1,247,432,097.56

Gold Coast Health Plan

$1,099,020,324.61

Health Net Community Solutions, Inc.

$6,576,100,766.73

Health Plan of San Joaquin

$1,661,314,624.30

Health Plan of San Mateo

$822,880,738.51

Inland Empire Health Plan

$6,393,779,045.23

Kaiser Foundation Health Plan, Inc.

$2,512,005,980.82

Kern Family Health Care

$1,425,536,064.89

L.A. Care Health Plan

$10,447,952,122.94

Molina Healthcare of California

$2,132,209,749.79

Partnership HealthPlan of California

$4,064,791,396.06

San Francisco Health Plan

$1,057,528,182.82

Santa Clara Family Health Plan

$1,402,641,020.96

SCAN Health Plan

$85,449,856.89

D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Positive Health Care** Promptly when plan receives information about the change **Alameda Alliance for Health** Promptly when plan receives information about the change **Anthem Blue Cross Partnership Health Plan** Promptly when plan receives information about the change **Blue Shield of California Promise Health Plan** Promptly when plan receives information about the change **CalOptima Health** 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 Partnership Plan** Promptly when plan receives information about the change

Community Health Plan of Imperial Valley

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, Inc.

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 Foundation Health Plan, Inc.

Promptly when plan receives information about the change

Kern Family Health Care

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 HealthPlan 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

Topic XI: ILOS

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if “Yes”, which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter “0” for utilization.

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Positive Health Care** Not answered **Alameda Alliance for Health** Not answered **Anthem Blue Cross Partnership Health Plan** Not answered **Blue Shield of California Promise Health Plan** Not answered **CalOptima Health** Not answered **CalViva Health** Not answered **CenCal Health** Not answered **Central California Alliance for Health** Not answered **Community Health Group Partnership Plan** Not answered **Community Health Plan of Imperial Valley** Not answered **Contra Costa Health Plan** Not answered **Gold Coast Health Plan** Not answered **Health Net Community Solutions, Inc.** Not answered **Health Plan of San Joaquin** Not answered

Health Plan of San Mateo

Not answered

Inland Empire Health Plan

Not answered

Kaiser Foundation Health Plan, Inc.

Not answered

Kern Family Health Care

Not answered

L.A. Care Health Plan

Not answered

Molina Healthcare of California

Not answered

Partnership HealthPlan of California

Not answered

San Francisco Health Plan

Not answered

Santa Clara Family Health Plan

Not answered

SCAN Health Plan

Not answered

Topic XIII. Prior Authorization

Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If “Yes”, please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

> ⚠ **Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.**

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If “Yes”, please complete the following questions under each plan.	Not reporting data

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** 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** Enrollment Broker/Choice Counseling Beneficiary Outreach

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to “Review & submit.”

Number	Indicator	Response
F1	**Notes (optional)**	Not answered