Volume 2 of 3

Medi-Cal Managed Care External Quality Review Technical Report

July 1, 2019–June 30, 2020

Plan-Specific Evaluation Reports

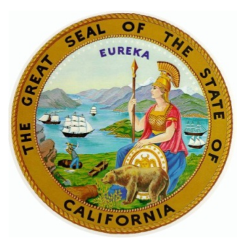
(Appendices A through FF)

Alternate Reporting Methods

(Appendix GG)

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

April 2021



Medi-Cal Managed Care
External Quality Review Technical Report

Appendix A:
Performance Evaluation Report
Access Dental Plan
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS' contracted Medi-Cal dental managed care (DMC) plan, Access Dental Plan ("Access Dental" or "the DMC plan"). The purpose of this appendix is to provide DMC plan-specific results of each activity and an assessment of the DMC plan's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to dental care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under the Medi-Cal Managed Care program (MCMC), and the term "member" refers to a person enrolled in a DMC plan. The review period for this DMC plan-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in Access Dental's 2020–21 plan-specific evaluation report. This DMC plan-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Dental Managed Care Plan Overview

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

Access Dental became operational as a DMC plan in Los Angeles County effective July 1, 2013, and in Sacramento County effective January 1, 2013. As of June 2020, Access Dental had 132,469 members in Los Angeles County and 125,745 in Sacramento County—for a total of 258,214 members.[1] This represents 36 percent of the DMC beneficiaries enrolled in Los Angeles County and 30 percent of DMC beneficiaries enrolled in Sacramento County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

Compliance Reviews Conducted

The following is a summary of the most recent review conducted for Access Dental. HSAG's compliance review summaries are based on final audit reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020). The description of the DHCS Audits and Investigations Division (A&I) Dental Audit may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site A&I Dental Audit of Access Dental. A&I conducted the audit from February 24, 2020, through February 28, 2020.

Table 2.1—DHCS A&I Dental Audit of Access Dental
Audit Review Period: January 1, 2019, through December 31, 2019

Category Evaluated	Deficiencies/ Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in the Quality Management category during the February 2020 Dental Audit of Access Dental.

Opportunities for Improvement—Compliance Reviews

Access Dental has the opportunity to work with DHCS to ensure the DMC plan fully resolves all findings from the February 2020 A&I Dental Audit. A&I identified findings in the Utilization Management, Access and Availability of Care, and Member's Rights categories.

3. Dental Managed Care Plan Performance Measures

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

Beginning with reporting year 2019, DHCS required DMC plans to submit both reporting units' audited performance measure rates reflecting measurement year data from the previous calendar year. In May 2020, Access Dental submitted to DHCS both reporting units' reporting year 2020 performance measure rates reflecting measurement year 2019 data (i.e., January 1, 2019, through December 31, 2019).

Performance Measure Results

Table 3.1 and Table 3.2 present Access Dental's reporting years 2019 and 2020 audited performance measure rates by domain for each DMC plan reporting unit. To allow HSAG to provide meaningful display of DMC plan performance, HSAG organized the performance measures according to health care areas that each measure affects (i.e., Access to Care and Preventive Care).

Table 3.1—Reporting Years 2019 and 2020 (Measurement Years 2018 and 2019) Dental Managed Care Plan Performance Measure Results
Access Dental—Los Angeles County

= Statistical testing result indicates that the reporting year 2020 rate is significantly better than the reporting year 2019 rate.

= Statistical testing result indicates that the reporting year 2020 rate is significantly worse than the reporting year 2019 rate.

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

Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

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

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

Not Tested = A reporting year 2019–20 rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance or because the data for this measure do not meet the assumptions for a Chi-square test of statistical significance.

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Access to Care			
Annual Dental Visits—Ages 0–20 Years	41.65%	40.82%	-0.84
Annual Dental Visits—Ages 21+ Years	15.92%	16.87%	0.95
Continuity of Care—Ages 0–20 Years	61.51%	62.18%	0.67
Continuity of Care—Ages 21+ Years	26.20%	30.00%	3.80
Exam/Oral Health Evaluations—Ages 0–20 Years	35.99%	35.95%	-0.03
Exam/Oral Health Evaluations—Ages 21+ Years	11.28%	11.95%	0.68
General Anesthesia—Ages 0–20 Years	72.22%	NA	Not Tested
General Anesthesia—Ages 21+ Years	70.45%	NA	Not Tested
Overall Utilization of Dental Services—One Year—Ages 0–20 Years	41.82%	40.96%	-0.86
Overall Utilization of Dental Services—One Year—Ages 21+ Years	15.85%	16.84%	0.99
Use of Dental Treatment Services—Ages 0–20 Years	17.76%	16.43%	-1.33
Use of Dental Treatment Services—Ages 21+ Years	10.09%	11.10%	1.01
Usual Source of Care—Ages 0–20 Years	32.10%	31.89%	-0.21
Usual Source of Care—Ages 21+ Years	6.34%	7.36%	1.02
Preventive Care			
Preventive Services to Filling—Ages 0–20 Years	84.06%	83.48%	-0.58
Preventive Services to Filling—Ages 21+ Years	46.36%	45.25%	-1.11
Sealants to Restoration Ratio (Surfaces)—Ages 6–9 Years	4.81	5.34	0.53

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Sealants to Restoration Ratio (Surfaces)—Ages 10–14 Years	3.11	3.66	0.55
Treatment/Prevention of Caries—Ages 0–20 Years	37.05%	36.46%	-0.58
Treatment/Prevention of Caries—Ages 21+ Years	7.36%	8.06%	0.70
Use of Preventive Services—Ages 0–20 Years	36.73%	36.38%	-0.35
Use of Preventive Services—Ages 21+ Years	7.12%	7.85%	0.73
Use of Sealants—Ages 6–9 Years	13.19%	13.68%	0.49
Use of Sealants—Ages 10–14 Years	5.77%	6.46%	0.69

Table 3.2—Reporting Years 2019 and 2020 (Measurement Years 2018 and 2019) Dental Managed Care Plan Performance Measure Results
Access Dental—Sacramento County

= Statistical testing result indicates that the reporting year 2020 rate is significantly better than the reporting year 2019 rate.

= Statistical testing result indicates that the reporting year 2020 rate is significantly worse than the reporting year 2019 rate.

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

Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

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

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Access to Care			
Annual Dental Visits—Ages 0–20 Years	35.70%	38.07%	2.38
Annual Dental Visits—Ages 21+ Years	16.63%	17.23%	0.60
Continuity of Care—Ages 0–20 Years	60.56%	31.17%	-29.39
Continuity of Care—Ages 21+ Years	28.87%	9.66%	-19.21
Exam/Oral Health Evaluations—Ages 0–20 Years	31.21%	31.61%	0.39
Exam/Oral Health Evaluations—Ages 21+ Years	10.97%	11.02%	0.05
General Anesthesia—Ages 0–20 Years	71.53%	78.51%	6.98
General Anesthesia—Ages 21+ Years	92.68%	100.00%	7.32
Overall Utilization of Dental Services—One Year—Ages 0–20 Years	35.88%	38.22%	2.33
Overall Utilization of Dental Services—One Year—Ages 21+ Years	16.59%	17.21%	0.63
Use of Dental Treatment Services—Ages 0–20 Years	16.26%	16.49%	0.23
Use of Dental Treatment Services—Ages 21+ Years	11.82%	12.43%	0.61
Usual Source of Care—Ages 0–20 Years	29.52%	31.17%	1.65
Usual Source of Care—Ages 21+ Years	8.31%	9.66%	1.35
Preventive Care			
Preventive Services to Filling—Ages 0–20 Years	79.47%	83.27%	3.80
Preventive Services to Filling—Ages 21+ Years	44.17%	43.17%	-1.00
Sealants to Restoration Ratio (Surfaces)—Ages 6–9 Years	4.53	4.55	0.02

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Sealants to Restoration Ratio (Surfaces)—Ages 10–14 Years	3.01	3.04	0.03
Treatment/Prevention of Caries—Ages 0–20 Years	31.40%	34.48%	3.08
Treatment/Prevention of Caries—Ages 21+ Years	8.45%	9.11%	0.66
Use of Preventive Services—Ages 0–20 Years	29.74%	33.21%	3.48
Use of Preventive Services—Ages 21+ Years	7.19%	7.58%	0.39
Use of Sealants—Ages 6–9 Years	10.13%	10.12%	-0.01
Use of Sealants—Ages 10–14 Years	5.57%	5.71%	0.14

Strengths—Performance Measures

Access Dental's performance measure results reflect improvement in both health care areas, with Los Angeles County showing statistically significant improvement for eight measures and Sacramento County showing statistically significant improvement for 11 measures.

Access to Care

Across both reporting units within the Access to Care health care area, 11 of 26 measure rates (42 percent) that HSAG could compare between reporting year 2019 and reporting year 2020 improved significantly from reporting year 2019 to reporting year 2020. These measures are listed below:

- *Annual Dental Visits—Ages 0–20 Years* in Sacramento County
- *Annual Dental Visits—Ages 21+ Years* in both reporting units
- *Continuity of Care—Ages 21+ Years* in Los Angeles County
- *Exam/Oral Health Evaluations—Ages 21+ Years* in Los Angeles County
- *Overall Utilization of Dental Services—One Year—Ages 0–20 Years* in Sacramento County
- *Overall Utilization of Dental Services—One Year—Ages 21+ Years* in both reporting units
- *Usual Source of Care—Ages 0–20 Years* in Sacramento County
- *Usual Source of Care—Ages 21+ Years* in both reporting units

Preventive Care

Across both reporting units within the Preventive Care health care area, eight of 20 measure rates (40 percent) improved significantly from reporting year 2019 to reporting year 2020. These measures are listed below:

- *Preventive Services to Filling—Ages 0–20 Years* in Sacramento County
- *Treatment/Prevention of Caries—Ages 0–20 Years* in Sacramento County
- *Treatment/Prevention of Caries—Ages 21+ Years* in both reporting units
- *Use of Preventive Services—Ages 0–20 Years* in Sacramento County
- *Use of Preventive Services—Ages 21+ Years* in both reporting units
- *Use of Sealants—Ages 10–14 Years* in Los Angeles County

Opportunities for Improvement—Performance Measures

For the following measures, Access Dental has the opportunity to identify the causes for the significant decline in the DMC plan's performance from reporting year 2019 to reporting year 2020 to prevent further decline in the measures' rates and ensure members are receiving needed dental care services:

- *Annual Dental Visits—Ages 0–20 Years* in Los Angeles County
  - The DMC plan may benefit from determining the factors that contributed to the significant improvement for this measure's rate in Sacramento County and test the successful strategies in Los Angeles County.
- *Continuity of Care—Ages 0–20 Years* in Sacramento County
- *Continuity of Care—Ages 21+ Years* in Sacramento County
  - The DMC plan may benefit from determining the factors that contributed to the significant improvement for this measure's rate in Los Angeles County and test the successful strategies in Sacramento County.
- *Overall Utilization of Dental Services—One Year—Ages 0–20 Years* in Los Angeles County
  - The DMC plan may benefit from determining the factors that contributed to the significant improvement for this measure's rate in Sacramento County and test the successful strategies in Los Angeles County.
- *Treatment/Prevention of Caries—Ages 0–20 Years* in Los Angeles County
  - The DMC plan may benefit from determining the factors that contributed to the significant improvement for this measure's rate in Sacramento County and test the successful strategies in Los Angeles County.

4. Performance Improvement Projects

DHCS requires DMC plans to conduct two quality improvement projects (QIPs) per year. DMC plans must participate in a DHCS-established and facilitated statewide QIP as well as an individual QIP that aligns with a demonstrated area in need of improvement. For the statewide QIP, DMC plans must submit two reports annually—one intervention progress report to HSAG, and an annual QIP submission to DHCS. For the individual QIP, DMC plans must use HSAG's rapid-cycle performance improvement project (PIP) process. Because DHCS requires DMC plans to use HSAG's rapid-cycle PIP process for their individual QIPs, HSAG refers to DMC plans' individual QIPs as individual PIPs.

Statewide Quality Improvement Project

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

Based on the reporting requirements, Access Dental submitted its second annual intervention progress report to HSAG in March 2020. The DMC plan reported on identified barriers and interventions conducted as of December 31, 2019. In April 2020, HSAG provided feedback to Access Dental on the intervention progress report. HSAG noted that Access Dental implemented the interventions in a timely manner. While the QIP results comparison between calendar year 2018 and calendar year 2019 indicated an improvement in Sacramento County, the DMC plan saw a decline in Los Angeles County.

HSAG suggested that Access Dental should:

- In the next annual intervention progress report, provide clear drivers, factors, and/or barriers that affect the QIP results.
- Revisit the causal/barrier analysis at least annually to reassess barriers; and in the next annual intervention progress report, provide a comprehensive list of the identified barriers ranked in order of priority.
- Link the interventions with identified barriers to ensure that the interventions will directly impact the QIP outcomes.
- Develop and implement intervention-specific evaluations to determine the effectiveness of each intervention and inform next steps.

Individual Performance Improvement Project

Rapid-Cycle Performance Improvement Project Overview

The following is an overview of HSAG's rapid-cycle PIP process that DMC plans followed when conducting their individual PIPs.

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

The following provides an overview of the Rapid-Cycle PIP modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Individual Performance Improvement Project Results and Findings

Using its own DMC plan-specific data, Access Dental selected annual dental visits for children ages 5 to 18 as its 2019–21 individual PIP topic. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the DMC plan's module submissions for the 2019–21 individual PIP as well as validation findings from the review period.

During the review period of this report, HSAG validated modules 1 and 2 for the DMC plan's *Increasing an Annual Dental Visit for Children, Ages 5–18* PIP. Upon initial review of the modules, HSAG determined that Access Dental met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of:
  - The SMART Aim statement.
  - The SMART Aim data collection methodology.
  - The SMART Aim run chart.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Labeling clearly the identified gaps or opportunities for improvement in the process map steps.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.

- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.

After receiving technical assistance from HSAG, Access Dental incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the DMC plan met all validation criteria for modules 1 and 2. Access Dental was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Access Dental successfully completed the second annual intervention progress report for the *Preventive Services Utilization* statewide QIP, providing all requested information. Additionally, using information gained from HSAG's PIP training, validation results, and technical assistance, Access Dental submitted all required documentation and met all criteria for the *Increasing an Annual Dental Visit for Children, Ages 5–18* individual PIP modules that the DMC plan completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each DMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 DMC plan-specific evaluation report. Based on HSAG's assessment of Access Dental's delivery of quality, accessible, and timely care through the activities described in the DMC plan's 2018–19 DMC plan-specific evaluation report, HSAG included no recommendations in Access Dental's 2018–19 DMC plan-specific evaluation report. Therefore, Access Dental had no recommendations for which it was required to provide the DMC plan's self-reported actions.

2019–20 Recommendations

Based on the overall assessment of Access Dental's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the DMC plan:

- For the following measures, identify the causes for the significant decline in the DMC plan's performance from reporting year 2019 to reporting year 2020 to prevent further decline in the measures' rates and ensure members are receiving needed dental care services:
  - *Annual Dental Visits—Ages 0–20 Years* in Los Angeles County
    - The DMC plan may benefit from determining the factors that contributed to the significant improvement for this measure's rate in Sacramento County and test the successful strategies in Los Angeles County.
  - *Continuity of Care—Ages 0–20 Years* in Sacramento County
  - *Continuity of Care—Ages 21+ Years* in Sacramento County
    - The DMC plan may benefit from determining the factors that contributed to the significant improvement for this measure's rate in Los Angeles County and test the successful strategies in Sacramento County.
  - *Overall Utilization of Dental Services–One Year—Ages 0–20 Years* in Los Angeles County
    - The DMC plan may benefit from determining the factors that contributed to the significant improvement for this measure's rate in Sacramento County and test the successful strategies in Los Angeles County.
  - *Treatment/Prevention of Caries—Ages 0–20 Years* in Los Angeles County
    - The DMC plan may benefit from determining the factors that contributed to the significant improvement for this measure's rate in Sacramento County and test the successful strategies in Los Angeles County.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix B:
Performance Evaluation Report
Aetna Better Health of California
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Aetna Better Health of California ("Aetna" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in Aetna's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

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

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

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

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

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

Aetna became operational in Sacramento and San Diego counties to provide MCMC services effective January 1, 2018. As of June 2020, Aetna had 10,300 members in Sacramento County and 13,167 in San Diego County—for a total of 23,467 members.[1] This represents 2 percent of the beneficiaries enrolled in Sacramento County and 2 percent of the beneficiaries enrolled in San Diego County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Aetna.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Aetna. A&I conducted the audits from April 22, 2019, through April 25, 2019. The audit period encompassed Aetna's first year of operation in MCMC and primarily focused on the MCP's development and implementation of systems and processes.

Note that while A&I conducted the on-site audits outside the review dates for this MCP-specific evaluation report, HSAG includes the audit results because DHCS issued the final reports on November 7, 2019, which is within the review period. Additionally, while the closeout letter was issued on September 22, 2020, which is outside the review period for this report, HSAG includes the information from the letter because it reflects full resolution of all findings from the April 2019 A&I Medical and State Supported Services Audits.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Aetna
Audit Review Period: April 1, 2018, through March 31, 2019

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	Corrective Action Plan (CAP) imposed and findings in this category rectified.
Case Management and Coordination of Care	Yes	CAP imposed and findings in this category rectified.
Access and Availability of Care	Yes	CAP imposed and findings in this category rectified.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	Yes	CAP imposed and findings in this category rectified.
Administrative and Organizational Capacity	Yes	CAP imposed and findings in this category rectified.

Category Evaluated	Findings (Yes/No)	Monitoring Status
State Supported Services	Yes	CAP imposed and findings in this category rectified.

Strengths—Compliance Reviews

In response to the CAP from the April 2019 A&I Medical and State Supported Services Audits of Aetna, the MCP provided documentation to DHCS that resulted in DHCS closing the CAP. Aetna's documentation reflected changes to policies and procedures to ensure that the MCP is compliant with DHCS' contract requirements in all evaluated categories.

Opportunities for Improvement—Compliance Reviews

Aetna has no outstanding findings from the April 2019 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Aetna chose to report all hybrid measures according to the reporting year 2020 measure specifications using measurement year 2019 data.

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs

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

must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.

- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of Aetna, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Aetna Better Health of California* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.8 for Aetna's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.8:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.

- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 and Table 3.2 present the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Aetna—Sacramento County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	23.36%
Childhood Immunization Status—Combination 10	S
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	75.19%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	63.10%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	43.33%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	46.67%
Developmental Screening in the First Three Years of Life—Total	28.57%
Immunizations for Adolescents—Combination 2	S
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	52.43%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	NA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	52.19%

Table 3.2—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Aetna—San Diego County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	28.22%
Childhood Immunization Status—Combination 10	25.97%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	83.33%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	66.03%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	NA
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	NA
Developmental Screening in the First Three Years of Life—Total	34.94%
Immunizations for Adolescents—Combination 2	S
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	64.51%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	S
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	49.07%

Women's Health Domain

Table 3.3 and Table 3.4 present the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.3—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Aetna—Sacramento County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	NA
Cervical Cancer Screening	39.90%
Chlamydia Screening in Women—Ages 16–20 Years	62.50%
Chlamydia Screening in Women—Ages 21–24 Years	55.71%
Chlamydia Screening in Women—Total	57.84%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	S
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	20.46%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	S
Contraceptive Care—All Women—LARC—Ages 21–44 Years	2.48%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	25.53%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	S
Prenatal and Postpartum Care—Postpartum Care	75.68%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	77.03%

Table 3.4—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Aetna—San Diego County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	NA
Cervical Cancer Screening	38.20%
Chlamydia Screening in Women—Ages 16–20 Years	45.90%
Chlamydia Screening in Women—Ages 21–24 Years	72.64%
Chlamydia Screening in Women—Total	62.87%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	19.07%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	24.19%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	S
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.08%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	33.68%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	S
Prenatal and Postpartum Care—Postpartum Care	79.55%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.55%

Behavioral Health Domain

Table 3.5 and Table 3.6 present the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.5—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Aetna—Sacramento County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	55.00%

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.00%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	NA
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	3.89%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	4.21%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Table 3.6—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Aetna—San Diego County

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

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	61.11%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.00%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	NA
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	14.05%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	10.49%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	15.04%

Acute and Chronic Disease Management Domain

Table 3.7 and Table 3.8 present the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.7—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Aetna—Sacramento County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	76.92%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	54.48
Asthma Medication Ratio—Total	NA
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	48.98%
Comprehensive Diabetes Care—HbA1c Testing—Total	75.51%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	S
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	50.22%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA
Plan All-Cause Readmissions—Expected Readmissions—Total	NA
*Plan All-Cause Readmissions—O/E Ratio—Total***	NA

Measure	Reporting Year 2020 Rate
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	0.00%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.8—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Aetna—San Diego County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	63.82%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	39.37
Asthma Medication Ratio—Total	NA
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	66.86%
Comprehensive Diabetes Care—HbA1c Testing—Total	75.00%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	S
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	42.22%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA
Plan All-Cause Readmissions—Expected Readmissions—Total	NA

Measure	Reporting Year 2020 Rate
*Plan All-Cause Readmissions—O/E Ratio—Total***	NA
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, Aetna will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.9 and Table 3.10 present the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.9—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Aetna—Sacramento County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either

the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	100.28	50.95	Not Tested	54.48
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	74.81%	Not Comparable	75.19%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	NA	63.44%	Not Comparable	63.10%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	NA	43.33%	Not Comparable	43.33%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	NA	NA	Not Comparable	46.67%
*Plan All-Cause Readmissions—Total***	NA	NA	Not Comparable	NA

Table 3.10—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Aetna—San Diego County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	90.91	37.48	Not Tested	39.37
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	83.23%	Not Comparable	83.33%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	NA	66.02%	Not Comparable	66.03%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	NA	NA	Not Comparable	NA

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	NA	NA	Not Comparable	NA
*Plan All-Cause Readmissions—Total***	NA	NA	Not Comparable	NA

Seniors and Persons with Disabilities—Performance Measure Findings

HSAG was unable to compare the reporting year 2020 SPD and non-SPD rates due to all SPD rates having denominators too low for Aetna to report valid rates.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Aetna's participation in California's Coordinated Care Initiative (CCI) as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Aetna report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

While Aetna participates in the CCI as an MLTSSP in both Sacramento and San Diego counties, in reporting year 2020 Aetna had no members in Sacramento County who met the MLTSS measure reporting criteria; therefore, Aetna has no reporting year 2020 MLTSS rates for Sacramento County.

Table 4.1 presents the reporting year 2020 rates for each required MLTSSP performance measure. Table 4.1 presents reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 4.1—Reporting Year 2020 MLTSSP Performance Measure Results Aetna—San Diego County

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

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA
Plan All-Cause Readmissions—Expected Readmissions—Total	NA
*Plan All-Cause Readmissions—O/E Ratio—Total***	NA

5. Performance Improvement Projects

Performance Improvement Project Overview

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

2019–21 Performance Improvement Projects

The following provides an overview of the Rapid-Cycle PIP modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, Aetna initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2019–21 Health Equity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Using its own MCP-specific data, Aetna identified cervical cancer screening among White women as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Cervical Cancer Screening* Health Equity PIP. Upon initial review of the modules, HSAG determined that Aetna met some required validation criteria; however, HSAG identified opportunities for improvement related to including:

- All required components of:
  - The SMART Aim statement.
  - The SMART Aim data collection methodology.

- The SMART Aim run chart.
- A process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.

After receiving technical assistance from HSAG, Aetna incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. Aetna was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, Aetna selected well-child visits for children ages 3 to 6 as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated Module 1 for the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. Upon initial review of the module, HSAG determined that Aetna met some required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of:

- The SMART Aim statement.
- The SMART Aim data collection methodology.
- The SMART Aim run chart.

After receiving technical assistance from HSAG, Aetna incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. Aetna was in the process of working on its Module 2 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

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

Opportunities for Improvement—Performance Improvement Projects

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

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

Aetna submitted the MCP's final PNA report to DHCS on August 6, 2020, and DHCS notified the MCP via email on August 10, 2020, that DHCS approved the report as submitted. While Aetna submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Based on HSAG's assessment of Aetna's delivery of quality, accessible, and timely care through the activities described in the MCP's 2018–19 MCP-specific evaluation report, HSAG included no recommendations in Aetna's 2018–19 MCP-specific evaluation report. Therefore, Aetna had no recommendations for which it was required to provide the MCP's self-reported actions.

2019–20 Recommendations

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

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

Medi-Cal Managed Care External Quality Review Technical Report

Appendix C: Performance Evaluation Report AIDS Healthcare Foundation

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted PSP, AIDS Healthcare Foundation ("AHF" or "the PSP"). The purpose of this appendix is to provide PSP-specific results of each activity and an assessment of the PSP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this PSP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in AHF's 2020–21 PSP-specific evaluation report. This PSP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Population-Specific Health Plan Overview

AHF is a PSP operating in Los Angeles County, providing services primarily to beneficiaries living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Due to AHF's unique membership, some of PSP's contracted requirements are different from MCP contract requirements. AHF became operational in Los Angeles County to provide MCMC services effective April 1995. As of June 2020, AHF had 632 members.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for AHF.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical Audit of AHF. A&I conducted the audit from February 4, 2020, through February 13, 2020. DHCS issued the final closeout letter on October 7, 2020, which is outside the review period for this report; however, HSAG includes the information from the letter because it reflects full resolution of the findings from the 2020 A&I Medical Audit.

Table 2.1—DHCS A&I Medical Audit of AHF
Audit Review Period: January 1, 2019, through December 31, 2019

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	Corrective action plan (CAP) imposed and findings in this category rectified.
Case Management and Coordination of Care	Yes	CAP imposed and findings in this category rectified.
Access and Availability of Care	Yes	CAP imposed and findings in this category rectified.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	No	No findings.
Administrative and Organizational Capacity	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in the Quality Management and Administrative and Organizational Capacity categories during the 2020 Medical Audit of AHF. Additionally, in response to the CAP from the 2020 A&I Medical Audit of AHF, the PSP provided documentation to DHCS that resulted in DHCS closing the CAP. AHF's documentation reflected changes to policies and

procedures to ensure the PSP is compliant with DHCS' standards within the Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, and Member's Rights categories.

Opportunities for Improvement—Compliance Reviews

AHF has no outstanding findings from the 2020 A&I Medical Audit; therefore, HSAG has no recommendations for the PSP in the area of compliance reviews.

3. Population-Specific Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by PSPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with PSPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by PSPs.

Hybrid Measure Reporting

PSPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to PSP and provider staff members related to COVID-19, DHCS allowed PSPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the PSP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

AHF chose to report all hybrid measures according to the reporting year 2020 measure specifications using measurement year 2019 data.

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

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[2] The reporting year is the year in which PSPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

DHCS-Established Performance Levels

To assess performance for each PSP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for select MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold PSPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all PSPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold PSPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all PSPs:

- ♦ Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. PSPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow PSPs flexibility regarding the Plan-Do-Study-Act (PDSA) cycle format and interventions. PSPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- ♦ Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. PSPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the PSP contracts authorize DHCS to impose sanctions on PSPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding PSPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

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

Performance Measure Validation Results

HSAG conducted an independent audit of AHF, and the *HEDIS 2020 Compliance Audit Final Report of Findings for AIDS Healthcare Foundation* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the PSP's performance measure rates, HSAG assessed the results. See Table 3.1 for AHF's performance measure results for reporting year 2020.

Note the following regarding Table 3.1:

- ♦ The table presents reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 PSP-specific evaluation reports and trending beginning in the 2021–22 PSP-specific evaluation reports.
- ♦ Based on DHCS not holding PSPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the PSP's reporting year 2020 performance measure results.

Table 3.1—Reporting Year 2020 Performance Measure Results
AHF—Los Angeles County

* A lower rate indicates better performance for this measure.

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Women's Health Domain	
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	NA
Contraceptive Care—All Women—LARC—Ages 21–44 Years	NA
Behavioral Health Domain	
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.00%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	NA
Acute and Chronic Disease Management Domain	
Adult BMI Assessment—Total	97.03%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total**	S
Comprehensive Diabetes Care—HbA1c Testing—Total	95.35%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years**	26.23%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years**	NA
Controlling High Blood Pressure—Total	60.00%
HIV Viral Load Suppression—Ages 18–64 Years	93.56%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years**	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years**	NA

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, AHF will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the PSP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding PSPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, AHF submitted final modules for its 2017–19 PSP-specific PIPs. HSAG provided final validation findings and encouraged the PSP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, AHF initiated the 2019–21 PSP-specific PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the PSP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Colorectal Cancer Screening Performance Improvement Project

AHF selected colorectal cancer screening as one of its 2017–19 PIP topics based on its PSP-specific data.

Table 4.1 provides the SMART Aim measure results reported by the PSP for its *Colorectal Cancer Screening* PIP.

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

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of colorectal cancer screening among members 50 to 75 years of age residing in Los Angeles County	58.26%	70.50%	No

Table 4.2 presents a description of the intervention that AHF tested for its *Colorectal Cancer Screening* PIP. The table also indicates the key driver and failure mode that the intervention addressed and whether the PSP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

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

Intervention	Key Driver and Failure Mode Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide eligible members with a gift card for colorectal cancer screening completion	♦ Member engagement ♦ Members do not find value in undergoing a colorectal cancer screening	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for AHF's *Colorectal Cancer Screening* PIP. In the modules, AHF documented that it tested a member incentive program. The PSP conducted outreach calls and sent text messages to inform eligible members about the colorectal cancer screening incentive program and to offer appointment scheduling assistance, if needed. The PSP sent gift cards to members upon receiving signed incentive forms from providers and validating the claims. As part of the intervention, AHF developed a real-time database to track eligible members' screening status and gift card receipt. While the PSP did not achieve the SMART Aim goal, as a result of the intervention, AHF made a process change for providers to receive automatic approvals for the screening referrals to lessen the time between members' initial appointments with providers and the actual colorectal cancer screenings. Additionally, the PSP learned from members that the incentive program had a positive impact on their decision to complete the colorectal cancer screening. AHF determined to adapt the intervention to further test the impact of the incentive on the colorectal cancer screening completion rate.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned AHF's *Colorectal Cancer Screening* PIP a final confidence level of *Low Confidence*.

2017–19 Diabetes Retinal Eye Exam Performance Improvement Project

AHF selected diabetes retinal eye exam as its second 2017–19 PIP topic based on its PSP-specific data.

Table 4.3 provides the SMART Aim measure results as reported by the PSP for its 2017–19 *Diabetes Retinal Eye Exam* PIP.

Table 4.3—AHF 2017–19 *Diabetes Retinal Eye Exam* PIP SMART Aim Measure Results

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

Table 4.4 presents a description of the intervention that AHF tested for its 2017–19 *Diabetes Retinal Eye Exam* PIP. The table also indicates the key driver and failure mode that the intervention addressed and whether the PSP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.4—AHF 2017–19 *Diabetes Retinal Eye Exam* PIP Intervention Testing Results

Intervention	Key Driver and Failure Mode Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide eligible members with a gift card for retinal eye exam completion	♦ Member engagement ♦ Members do not find value in undergoing a retinal eye exam	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for AHF's 2017–19 *Diabetes Retinal Eye Exam* PIP. In the modules, AHF documented that it tested a member incentive program. The PSP conducted outreach calls and sent text messages to inform eligible members about the retinal eye exam incentive program and to offer appointment scheduling assistance, if needed. The PSP sent gift cards to members upon receiving signed incentive forms from providers and validating the claims. As part of the intervention, AHF developed a real-time database to track eligible members' exam completion status and gift card receipt. AHF documented that it made a process change to allow members to make ophthalmologist appointments without prior authorization. Additionally, the PSP learned from members that the incentive program had a positive impact on their decision to complete the retinal eye exams. AHF determined to adapt the intervention to further test the impact of the incentive on the retinal eye exam completion rate. The SMART Aim run chart indicated that the PSP achieved the SMART Aim goal prior to the start of the intervention testing, and while the monthly SMART Aim rate fluctuated, the PSP did not achieve the SMART Aim goal during the intervention testing period.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned AHF's 2017–19 *Diabetes Retinal Eye Exam* PIP a final confidence level of *Low Confidence*.

2019–21 Diabetes Retinal Eye Exam Performance Improvement Project

Using its own PSP-specific data, AHF determined to continue to focus on diabetes retinal eye exams as its 2019–21 PIP topic.

During the review period of this report, HSAG validated modules 1 through 3 for the PSP's 2019–21 *Diabetes Retinal Eye Exam* PIP. Upon initial review of Module 1, HSAG determined that AHF met some required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of the SMART Aim statement and SMART Aim run chart. After receiving technical assistance from HSAG, AHF incorporated HSAG's feedback into Module 1; and upon final review, HSAG determined that the PSP met all validation criteria for Module 1. AHF met all validation criteria for modules 2 and 3 in its initial submission.

Table 4.5 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the PSP's 2019–21 *Diabetes Retinal Eye Exam* PIP.

Table 4.5—AHF 2019–21 *Diabetes Retinal Eye Exam* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of retinal eye exams among members 18 to 75 years of age who are living with diabetes	44%	64%

Table 4.6 presents a description of the interventions that AHF selected to test for its 2019–21 *Diabetes Retinal Eye Exam* PIP. The table also indicates the failure modes that each intervention aims to address.

Table 4.6—AHF 2019–21 *Diabetes Retinal Eye Exam* PIP Intervention Testing

Intervention	Failure Modes Addressed
Make retinal eye cameras available to members at their primary care provider's office and/or during home visits	♦ Members refuse to visit eye care specialists ♦ Eye care specialists do not screen patients for diabetes
Provide member education on signs and symptoms of diabetes	♦ Members are not interested in understanding the treatment plan and/or provider instructions ♦ Members do not understand providers' explanation about the treatment plan ♦ Members do not disclose diabetic status

Intervention	Failure Modes Addressed
Conduct outreach to provide member education on diabetes management and health coaching regarding behaviors	♦ Members are not interested in understanding the treatment plan and/or provider instructions ♦ Members do not understand providers' explanations about the treatment plan ♦ Providers do not provide members with treatment plans ♦ Members do not disclose diabetic status ♦ Members do not experience/mention any symptoms when visiting eye care specialists
Provide member education on the importance of retinal eye exams and dilation	♦ Members do not understand the importance of retinal eye exams ♦ Members refuse to visit eye care specialists ♦ Members refuse retinal eye exams due to side effects
Ensure that members have scheduled transportation on appointment days	♦ Specialist locations are inconvenient for members
Expand vision provider network	♦ Specialists do not offer convenient office hours

While AHF advanced to the intervention testing phase, the PIP did not progress to the point where the PSP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

2019–21 Controlling Hight Blood Pressure Performance Improvement Project

AHF selected controlling high blood pressure as its second 2019–21 PIP topic based on its PSP-specific data.

During the review period for this report, HSAG validated modules 1 and 2 for the PSP's *Controlling High Blood Pressure* PIP. Upon initial review of the modules, HSAG determined that AHF met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of:
  - The SMART Aim data collection methodology.
  - The SMART Aim run chart.

- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.

After receiving technical assistance from HSAG, AHF incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the PSP met all validation criteria for modules 1 and 2. AHF was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, AHF identified interventions that it can adapt to improve members' compliance with colorectal cancer screenings and diabetes retinal eye exams.

Opportunities for Improvement—Performance Improvement Projects

AHF has the opportunity to monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Colorectal Cancer Screening* and *Diabetes Retinal Eye Exam* PIPs. The PSP should apply lessons learned from these PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the seniors and persons with disabilities population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

AHF submitted the PSP's PNA report to DHCS on July 30, 2020, and DHCS notified the PSP via email on August 7, 2020, that DHCS approved the report as submitted. While AHF submitted the PNA report and DHCS sent the email outside the review period for this PSP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Based on HSAG's assessment of AHF's delivery of quality, accessible, and timely care through the activities described in the PSP's 2018–19 PSP-specific evaluation report, HSAG included no recommendations in AHF's 2018–19 PSP-specific evaluation report. Therefore, AHF had no recommendations for which it was required to provide the PSP's self-reported actions.

2019–20 Recommendations

Based on the overall assessment of AHF's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the PSP:

- Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Colorectal Cancer Screening* and *Diabetes Retinal Eye Exam* PIPs.
- Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix D:
Performance Evaluation Report
Alameda Alliance for Health
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Alameda Alliance for Health ("AAH" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in AAH's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

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

AAH became operational in Alameda County to provide MCMC services effective 1996. As of June 2020, AAH had 250,619 members.[1] This represents 81 percent of the beneficiaries enrolled in Alameda County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for AAH. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of AAH. A&I conducted the audits from June 10, 2019, through June 21, 2019. A&I assessed AAH's compliance with its DHCS contract and determined to what extent the MCP had implemented its CAP from the 2018 Medical and State Supported Services Audits. Note that the CAP from the 2018 audits is still open.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of AAH
Audit Review Period: June 1, 2018, through May 31, 2019

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

Strengths—Compliance Reviews

While the CAP from the 2018 A&I Medical and State Supported Services Audits is still open, AAH provided information on the steps the MCP has taken to fully resolve the findings from the audits. (See Table 7.1.)

Opportunities for Improvement—Compliance Reviews

AAH has the opportunity to work with DHCS to fully resolve the findings from the 2018 and 2019 A&I Medical and State Supported Services Audits. A&I identified repeat findings in all six categories reviewed during the 2019 Medical Audit.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures AAH chose to report using one or both of these two options.

[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of AAH, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Alameda Alliance for Health* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for AAH's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
AAH—Alameda County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	59.12%
Childhood Immunization Status—Combination 10	52.80%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	94.12%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	86.15%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	89.33%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	88.32%
Developmental Screening in the First Three Years of Life—Total	32.67%

Measure	Reporting Year 2020 Rate
Immunizations for Adolescents—Combination 2	55.23%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	93.70%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	64.48%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	82.62%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
AAH—Alameda County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	62.82%
Cervical Cancer Screening	63.54%
Chlamydia Screening in Women—Ages 16–20 Years	59.11%
Chlamydia Screening in Women—Ages 21–24 Years	59.62%
Chlamydia Screening in Women—Total	59.34%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	19.74%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.11%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	4.41%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.53%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	7.43%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	12.46%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	45.27%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	39.49%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	3.25%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	28.38%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	16.86%
Prenatal and Postpartum Care—Postpartum Care	79.56%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.08%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
AAH—Alameda County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	69.74%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	54.94%

Measure	Reporting Year 2020 Rate
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	40.49%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	50.55%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.07%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	2.38%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
AAH—Alameda County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	94.03%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	44.11
Asthma Medication Ratio—Total	59.93%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	28.22%
Comprehensive Diabetes Care—HbA1c Testing—Total	89.29%

Measure	Reporting Year 2020 Rate
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	12.96%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	64.23%
HIV Viral Load Suppression—Ages 18–64 Years	14.76%
HIV Viral Load Suppression—Ages 65+ Years	S
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.94%
Plan All-Cause Readmissions—Expected Readmissions—Total	10.26%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.07
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.88%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, AAH will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations AAH—Alameda County

[green] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

[red] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	78.77	40.39	Not Tested	44.11
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	94.12%	Not Comparable	94.12%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	88.62%	86.10%	2.52	86.15%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	92.83%	89.20%	3.63	89.33%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	86.11%	88.42%	-2.31	88.32%
*Plan All-Cause Readmissions—Total***	12.44%	10.06%	2.38	10.94%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that AAH stratified by the SPD and non-SPD populations and for which HSAG could compare reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results:

- The reporting year 2020 SPD rate was significantly better than the reporting year 2020 non-SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years* measure.
- Members ages 12 to 19 years in the SPD population had significantly fewer instances of a visit with a primary care provider (PCP) during the measurement year than members in this age group in the non-SPD population in reporting year 2020. The significant differences may be attributed to these members choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from PCPs.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, AAH submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, AAH initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

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

Table 4.1 provides the SMART Aim measure results reported by the MCP for its *Diabetes HbA1c Testing* Disparity PIP.

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

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of HbA1c testing among African-American males ages 18 to 75 in Alameda County	73.12%	79.00%	No

Table 4.2 presents a description of the intervention that AAH tested for its *Diabetes HbA1c Testing* Disparity PIP. The table also indicates the key drivers and failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

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

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Call non-compliant members to educate them on the need for HbA1c testing, address any barriers, and schedule a convenient time for a lab draw	♦ Meaningful member engagement ♦ Members understand the need for HbA1c testing but do not prioritize it ♦ Members are inconsistently provided information on the importance of or need for their HbA1c testing	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for AAH's *Diabetes HbA1c Testing* Disparity PIP. In the modules, AAH documented that it tested the telephonic outreach intervention from April 2019 through June 2019. The MCP determined that the telephonic outreach was much more successful with this population as compared to other populations for which the MCP has conducted telephonic outreach. Based on the intervention testing outcomes, the MCP decided to adapt the intervention. Prior to testing the telephonic outreach intervention, AAH planned to test the effectiveness of conducting point-of-care HbA1c testing at the provider site; however, due to staffing issues the MCP was unable to test this intervention. Despite AAH's efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned AAH's *Diabetes HbA1c Testing* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on AAH's reporting year 2017 performance measure results, the MCP selected children's and adolescents' access to primary care physicians as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure results as reported by the MCP for its *Children/Adolescent Access to Primary Care Physicians* PIP.

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

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

Table 4.4 presents a description of the intervention that AAH tested for its *Children/Adolescent Access to Primary Care Physicians* PIP. The table also indicates the failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

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

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Outreach to members and provide an incentive to promote adolescent well-care visits	♦ Lack of education around the need for preventive care ♦ Lack of motivation to seek care	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for AAH's *Children/Adolescent Access to Primary Care Physicians* PIP. In the modules, AAH documented that it tested a member incentive and outreach intervention from December 2018 through June 2019. The MCP documented that it outreached to 164 members in December 2018 and 159 members in March 2019. In total, 32 of the outreached members completed a primary care visit; however, only 18 members returned a gift card acknowledgement form. The MCP determined that the intervention appeared to be ineffective in educating members on the need for teen preventive care visits and incentivizing them to schedule those visits. The MCP decided to adapt the intervention by offering a $25 movie gift card as an incentive rather than a $25 Target gift card and test whether a movie gift card is a more appealing incentive for teens to visit their PCPs. Although the MCP achieved the SMART Aim goal, it was reached and sustained prior to the start of intervention testing. Therefore, the intervention the MCP tested could not be clearly linked to the improvement.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned AAH's *Children/Adolescent Access to Primary Care Physicians* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, AAH identified well-child visits in the first 15 months of life as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 through 3 for the MCP's *Well-Child Visits in the First 15 months of Life* Health Equity PIP. Upon initial review of the modules, HSAG determined that AAH met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim and SMART Aim run chart.
- Linking logically the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.
- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.
- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.
- Including all required components of the Intervention Plan.
- Ensuring that the intervention effectiveness measure was appropriate for the intervention.
- Ensuring that the data collection process was appropriate for the intervention effectiveness measure.

After receiving technical assistance from HSAG, AAH incorporated HSAG's feedback into modules 1 through 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. AAH was in the process of working on its Module 3 resubmission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, AAH selected well-child visits in the third, fourth, fifth, and sixth years of life as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 through 3 for the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. Upon initial review of the modules, HSAG determined that AAH met all Module 2 validation criteria in its initial submission; however, HSAG identified opportunities for improvement related to the following modules 1 and 3 validation criteria:

- Including all required components of the:
  - SMART Aim.
  - SMART Aim data collection methodology.
  - SMART Aim run chart.
  - Intervention Plan.
- Ensuring that the data collection process was appropriate for the intervention effectiveness measure.

After receiving technical assistance from HSAG, AAH incorporated HSAG's feedback into Module 1; upon final review, HSAG determined that the MCP met all validation criteria for Module 1. AAH received the initial Module 3 validation findings when DHCS determined to end the 2019–21 PIPs; therefore, the MCP did not have an opportunity to incorporate HSAG's feedback into Module 3.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, AAH identified interventions that it can adapt to improve HbA1c testing among its African-American male members as well as access to PCPs for its adolescent members.

Opportunities for Improvement—Performance Improvement Projects

AAH has the opportunity to monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs. The MCP should apply lessons learned from these PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

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

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

AAH submitted the MCP's PNA report to DHCS on June 30, 2020, and DHCS notified the MCP via email on July 15, 2020, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 7.1 provides EQR recommendations from AAH's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of AAH's self-reported actions.

Table 7.1—AAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
Resolve all findings from the June 2018 A&I Medical and State Supported Services Audits of AAH.	AAH has worked consistently to address all findings from the 2018 audits. The MCP has updated policy documents and workflows, provided training for staff members and providers, and worked with our delegate partners in addressing all findings related to delegation. We have completed our internal work to address all 38 findings. The MCP has also completed an internal verification process for 35 of the 38 findings. While AAH has not received official CAP closure notification from DHCS, we continue to work with the agency's team in our ongoing efforts to adhere to all regulatory and contractual requirements and provide the best services to our members.

Assessment of MCP's Self-Reported Actions

HSAG reviewed AAH's self-reported actions in Table 7.1 and determined that AAH adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. While AAH has not fully resolved all findings from the 2018 A&I Medical and State Supported Services Audits, the MCP described steps it has taken to address the findings, including modifying policies and procedures, conducting staff member and provider trainings, and developing solutions with delegated partners. Additionally, AAH indicated that it continues to work with DHCS to ensure the MCP meets all contractual requirements.

2019–20 Recommendations

Based on the overall assessment of AAH's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to fully resolve the findings from the 2018 and 2019 A&I Medical and State Supported Services Audits.
- Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs.
- Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix E:
Performance Evaluation Report
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan ("Anthem Blue Cross" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in Anthem Blue Cross' 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific

activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

Anthem Blue Cross operated in 28 counties during the July 1, 2019, through June 30, 2020, review period for this report. Anthem Blue Cross, a full-scope MCP, delivers services to its members under the Two-Plan Model in eight counties, the Regional model in 18 counties, the Geographic Managed Care (GMC) model in one county, and the San Benito model in one county.

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

Anthem Blue Cross' Two-Plan Model

Anthem Blue Cross delivers services to its members as a "Local Initiative" MCP and commercial plan under the Two-Plan Model. Table 1.1 shows the counties in which Anthem Blue Cross provided services to its members under the Two-Plan Model and denotes for each county which MCP is the commercial plan and which is the Local Initiative.

Table 1.1—Anthem Counties Under the Two-Plan Model

County	Commercial Plan	Local Initiative Plan
Alameda	Anthem Blue Cross	Alameda Alliance for Health
Contra Costa	Anthem Blue Cross	Contra Costa Health Plan
Fresno	Anthem Blue Cross	CalViva Health
Kings	Anthem Blue Cross	CalViva Health
Madera	Anthem Blue Cross	CalViva Health
San Francisco	Anthem Blue Cross	San Francisco Health Plan
Santa Clara	Anthem Blue Cross	Santa Clara Family Health Plan

County	Commercial Plan	Local Initiative Plan
Tulare	Health Net Community Solutions, Inc.	Anthem Blue Cross

Anthem Blue Cross' Geographic Managed Care Model

Although the GMC model currently operates in San Diego and Sacramento counties, Anthem Blue Cross only operates in Sacramento County. In the GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county). In addition to Anthem Blue Cross, Sacramento County's beneficiaries may select from the following MCPs:

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

Anthem Blue Cross' Regional Model

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

Anthem Blue Cross' Enrollment

Table 1.2 shows the counties in which Anthem Blue Cross provides MCMC services, Anthem Blue Cross' enrollment for each county, the MCP's total number of members, and the percentage of beneficiaries in the county enrolled in Anthem Blue Cross as of June 2020.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

Table 1.2—Anthem Blue Cross Enrollment as of June 2020

County	Enrollment as of June 2020	Percentage of Beneficiaries in the County Enrolled in Anthem Blue Cross
Alameda	58,496	19%
Alpine	142	67%
Amador	4,834	78%
Butte	22,057	36%
Calaveras	4,523	47%
Colusa	4,552	58%
Contra Costa	26,885	13%
El Dorado	9,178	32%
Fresno	107,750	27%
Glenn	2,582	25%
Inyo	2,196	54%
Kings	19,423	39%
Madera	20,344	35%
Mariposa	3,267	80%
Mono	1,574	64%
Nevada	11,310	57%
Placer	28,149	61%
Plumas	2,628	51%
Sacramento	179,235	41%
San Benito	8,076	100%
San Francisco	18,161	12%
Santa Clara	66,046	21%
Sierra	347	60%
Sutter	20,955	66%
Tehama	8,881	42%
Tulare	96,752	47%

County	Enrollment as of June 2020	Percentage of Beneficiaries in the County Enrolled in Anthem Blue Cross
Tuolumne	5,132	51%
Yuba	16,212	63%
Total	**749,687**	

Under the Regional model, DHCS allows Anthem Blue Cross to combine data from multiple counties to form two single reporting units—Region 1 and Region 2. The counties within each of these reporting units are as follows:

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

The remaining 10 counties in which Anthem Blue Cross operates are each reported as a single reporting unit.

- Alameda County
- Contra Costa County
- Fresno County
- Kings County
- Madera County
- Sacramento County
- San Benito County
- San Francisco County
- Santa Clara County
- Tulare County

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Anthem Blue Cross.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Anthem Blue Cross. A&I conducted the audits from September 30, 2019, through October 11, 2019. DHCS issued the final closeout letter on December 4, 2020, which is outside the review period for this report; however, HSAG includes the information from the letter because it reflects full resolution of the findings from the 2019 A&I Medical Audit.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Anthem Blue Cross
Audit Review Period: October 1, 2018, through September 30, 2019

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	Corrective action plan (CAP) imposed and findings in this category rectified.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	Yes	CAP imposed and findings in this category rectified.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	No	No findings.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Follow-up on 2017 and 2018 A&I Medical Audits of Anthem Blue Cross

A&I conducted Medical Audits of Anthem Blue Cross in 2017 and 2018, covering the review periods of November 1, 2016, through October 31, 2017, and October 1, 2017, through September 30, 2018, respectively. HSAG provided summaries of the audit results and status in Anthem Blue Cross' 2017–18 and 2018–19 MCP-specific evaluation reports. When the 2018–19 MCP-specific evaluation report was produced, the MCP's CAPs from both audits were in progress and under review by DHCS. Two letters from DHCS, both dated July 28, 2020, indicated that Anthem Blue Cross provided DHCS with additional information regarding the CAPs, and that DHCS had reviewed the information and closed the CAPs. The letters indicated that DHCS would monitor the MCP's full implementation of the CAPs during the subsequent audit. Note that while the CAP closeout letters were sent outside the review dates for this MCP-specific evaluation report, HSAG includes the information because it reflects full resolution of all findings from the 2017 and 2018 A&I Medical Audits.

Strengths—Compliance Reviews

During the 2019 Medical and State Supported Services Audits of Anthem Blue Cross, A&I identified no findings in the Case Management and Coordination of Care, Quality Management, Administrative and Organizational Capacity, and State Supported Services categories. Additionally, Anthem Blue Cross provided documentation to DHCS that resulted in DHCS closing the CAPs from the 2017, 2018, and 2019 A&I Medical Audits of the MCP.

Opportunities for Improvement—Compliance Reviews

Anthem Blue Cross has no outstanding findings from the 2017, 2018, or 2019 A&I Medical Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures Anthem Blue Cross chose to report using one or both of these two options.

[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of Anthem Blue Cross, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Anthem Blue Cross Partnership Plan* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.48 for Anthem Blue Cross' performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.48:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 through Table 3.12 present the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Alameda County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	47.45%
Childhood Immunization Status—Combination 10	49.88%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	88.51%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	77.90%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	82.94%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	81.28%
Developmental Screening in the First Three Years of Life—Total	22.24%
Immunizations for Adolescents—Combination 2	44.04%

Measure	Reporting Year 2020 Rate
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	82.00%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	42.93%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.13%

Table 3.2—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Contra Costa County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	45.50%
Childhood Immunization Status—Combination 10	44.35%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	91.75%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	83.18%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	87.10%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	83.21%
Developmental Screening in the First Three Years of Life—Total	33.79%
Immunizations for Adolescents—Combination 2	36.50%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	82.00%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	42.86%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	79.26%

Table 3.3—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Fresno County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	39.17%
Childhood Immunization Status—Combination 10	33.82%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	93.17%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	84.76%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	84.56%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	80.98%
Developmental Screening in the First Three Years of Life—Total	32.42%
Immunizations for Adolescents—Combination 2	36.50%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	82.00%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	22.63%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.48%

Table 3.4—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Kings County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	45.99%
Childhood Immunization Status—Combination 10	33.82%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	95.19%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	86.52%

Measure	Reporting Year 2020 Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	88.35%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	86.01%
Developmental Screening in the First Three Years of Life—Total	4.97%
Immunizations for Adolescents—Combination 2	35.04%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	82.00%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	31.50%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.80%

Table 3.5—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Madera County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	60.83%
Childhood Immunization Status—Combination 10	38.20%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	95.30%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	91.48%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	94.02%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	90.90%
Developmental Screening in the First Three Years of Life—Total	49.30%
Immunizations for Adolescents—Combination 2	61.80%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	82.00%

Measure	Reporting Year 2020 Rate
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	33.73%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	82.08%

Table 3.6—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	44.77%
Childhood Immunization Status—Combination 10	33.82%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	95.15%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	88.12%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	89.66%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	86.71%
Developmental Screening in the First Three Years of Life—Total	42.28%
Immunizations for Adolescents—Combination 2	26.76%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	82.00%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	37.47%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.60%

Table 3.7—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	41.61%
Childhood Immunization Status—Combination 10	33.82%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	94.06%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	83.68%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	84.51%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	83.46%
Developmental Screening in the First Three Years of Life—Total	35.17%
Immunizations for Adolescents—Combination 2	31.87%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	82.00%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	35.52%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.80%

Table 3.8—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Sacramento County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	49.39%
Childhood Immunization Status—Combination 10	33.82%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	92.54%

Measure	Reporting Year 2020 Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	83.06%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	82.80%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	80.96%
Developmental Screening in the First Three Years of Life—Total	55.13%
Immunizations for Adolescents—Combination 2	39.66%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	82.00%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	14.84%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.49%

Table 3.9—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—San Benito County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	38.44%
Childhood Immunization Status—Combination 10	33.82%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	93.75%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	84.35%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	84.80%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	82.29%
Developmental Screening in the First Three Years of Life—Total	47.08%
Immunizations for Adolescents—Combination 2	24.29%

Measure	Reporting Year 2020 Rate
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	82.00%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	30.00%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.80%

Table 3.10—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—San Francisco County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	45.74%
Childhood Immunization Status—Combination 10	49.68%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	92.91%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	85.15%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	86.56%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	86.27%
Developmental Screening in the First Three Years of Life—Total	33.25%
Immunizations for Adolescents—Combination 2	46.23%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	82.00%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	51.76%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.99%

Table 3.11—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Santa Clara County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	47.69%
Childhood Immunization Status—Combination 10	44.28%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	93.36%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	85.24%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	87.12%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	83.38%
Developmental Screening in the First Three Years of Life—Total	35.74%
Immunizations for Adolescents—Combination 2	43.80%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	82.00%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	32.85%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.22%

Table 3.12—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Tulare County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	55.23%
Childhood Immunization Status—Combination 10	35.04%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	97.06%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	90.95%

Measure	Reporting Year 2020 Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	91.90%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	90.34%
Developmental Screening in the First Three Years of Life—Total	17.81%
Immunizations for Adolescents—Combination 2	45.50%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	82.00%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	32.85%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.32%

Assessment of Improvement Plans—Children's Health Domain

In April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Anthem Blue Cross conducted as part of its IP prior to April 2020.

Based on reporting year 2019 performance measure results, DHCS required Anthem Blue Cross to submit IPs for the following measures within the Children's Health Domain:

- *Childhood Immunization Status—Combination 3* in Region 2, Sacramento County, and San Benito County
  - Note that DHCS required MCPs to report rates for the *Childhood Immunization Status—Combination 10* measure in reporting year 2020 in place of the *Childhood Immunization Status—Combination 3* measure; therefore, Anthem Blue Cross' IP quality improvement activities focused on the *Childhood Immunization Status—Combination 10* measure.
- *Immunizations for Adolescents—Combination 2* in Region 1 and San Benito County
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in San Benito County

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of Anthem Blue Cross' performance related to measures within the Children's Health domain for which the MCP conducted PDSA cycles or a PIP.

Childhood Immunizations

To address Anthem Blue Cross' performance below the minimum performance level for the *Childhood Immunization Status—Combination 10* measure in Region 2, Sacramento County, and San Benito County, DHCS approved the MCP to conduct a *Childhood Immunizations—Combination 10* PIP in place of conducting PDSA cycles. HSAG includes a summary of Anthem Blue Cross' progress on the *Childhood Immunizations—Combination 10* PIP in Section 5 of this report ("Performance Improvement Projects").

Adolescent Immunizations

DHCS approved Anthem Blue Cross to conduct PDSA cycles to address the MCP's performance below the minimum performance level for the *Immunizations for Adolescents—Combination 2* measure in Region 1 and San Benito County.

Anthem Blue Cross partnered with a clinic in San Benito County to test whether designating a clinic-based outreach specialist and implementing an electronic health record (EHR) member recall dashboard would result in improved immunization compliance for adolescent members seen at the clinic. The new dashboard allowed the outreach specialist to identify adolescent members in need of immunizations. Anthem Blue Cross also partnered with the clinic to improve data exchange between the clinic's EHR system and the California Immunization Registry. The data exchange improved member data collection and eliminated the need to manually document immunizations. The positive results from the PDSA cycle led to the clinic creating a permanent position to conduct member outreach.

Well-Child Visits

To address Anthem Blue Cross' performance below the minimum performance level for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in San Benito County, DHCS approved the MCP to conduct a *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP in place of conducting PDSA cycles. HSAG includes a summary of Anthem Blue Cross' progress on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP in Section 5 of this report ("Performance Improvement Projects").

Women's Health Domain

Results—Women's Health Domain

Table 3.13 through Table 3.24 present the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.13—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Alameda County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	49.04%
Cervical Cancer Screening	54.01%
Chlamydia Screening in Women—Ages 16–20 Years	64.05%
Chlamydia Screening in Women—Ages 21–24 Years	69.14%
Chlamydia Screening in Women—Total	66.45%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	21.77%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	20.06%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	4.82%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.08%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	12.50%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	35.48%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	36.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	3.75%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	16.75%
Prenatal and Postpartum Care—Postpartum Care	73.97%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.62%

Table 3.14—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Contra Costa County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	50.44%
Cervical Cancer Screening	57.18%
Chlamydia Screening in Women—Ages 16–20 Years	63.89%
Chlamydia Screening in Women—Ages 21–24 Years	71.26%
Chlamydia Screening in Women—Total	66.77%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	16.21%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	21.55%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.30%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.55%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.93%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	38.30%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	14.89%
Prenatal and Postpartum Care—Postpartum Care	67.16%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.31%

Table 3.15—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Fresno County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	49.67%
Cervical Cancer Screening	51.58%
Chlamydia Screening in Women—Ages 16–20 Years	55.22%
Chlamydia Screening in Women—Ages 21–24 Years	68.52%
Chlamydia Screening in Women—Total	62.03%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.12%

Measure	Reporting Year 2020 Rate
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.17%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	1.87%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.70%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	7.25%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	34.04%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	35.01%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.32%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	6.51%
Prenatal and Postpartum Care—Postpartum Care	68.86%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.54%

Table 3.16—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Kings County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	52.06%
Cervical Cancer Screening	54.50%
Chlamydia Screening in Women—Ages 16–20 Years	52.78%
Chlamydia Screening in Women—Ages 21–24 Years	73.99%
Chlamydia Screening in Women—Total	63.73%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.02%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	27.92%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.27%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.77%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	5.42%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	43.33%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.08%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	17.50%

Measure	Reporting Year 2020 Rate
Prenatal and Postpartum Care—Postpartum Care	78.51%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.83%

Table 3.17—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Madera County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	50.60%
Cervical Cancer Screening	63.17%
Chlamydia Screening in Women—Ages 16–20 Years	46.60%
Chlamydia Screening in Women—Ages 21–24 Years	63.55%
Chlamydia Screening in Women—Total	55.24%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.11%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	27.70%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	1.18%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.45%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.73%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	41.15%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	11.50%
Prenatal and Postpartum Care—Postpartum Care	68.28%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.59%

Table 3.18—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	49.98%
Cervical Cancer Screening	54.99%
Chlamydia Screening in Women—Ages 16–20 Years	44.55%
Chlamydia Screening in Women—Ages 21–24 Years	56.22%
Chlamydia Screening in Women—Total	50.25%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	20.97%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	26.30%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.18%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.16%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.21%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	30.23%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	37.41%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	6.21%
Prenatal and Postpartum Care—Postpartum Care	75.91%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	77.62%

Table 3.19—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	51.93%
Cervical Cancer Screening	55.47%
Chlamydia Screening in Women—Ages 16–20 Years	47.41%
Chlamydia Screening in Women—Ages 21–24 Years	55.77%
Chlamydia Screening in Women—Total	51.01%

Measure	Reporting Year 2020 Rate
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	26.05%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	26.12%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.78%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.27%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.16%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	21.82%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	37.13%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	7.47%
Prenatal and Postpartum Care—Postpartum Care	65.69%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.91%

Table 3.20—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Sacramento County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	56.97%
Cervical Cancer Screening	57.18%
Chlamydia Screening in Women—Ages 16–20 Years	67.69%
Chlamydia Screening in Women—Ages 21–24 Years	67.59%
Chlamydia Screening in Women—Total	67.64%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	16.74%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	24.50%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.54%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.86%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	4.57%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	27.84%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	28.31%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.70%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	11.93%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	8.36%

Measure	Reporting Year 2020 Rate
Prenatal and Postpartum Care—Postpartum Care	72.02%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.43%

Table 3.21—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—San Benito County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	57.24%
Cervical Cancer Screening	57.42%
Chlamydia Screening in Women—Ages 16–20 Years	36.63%
Chlamydia Screening in Women—Ages 21–24 Years	53.33%
Chlamydia Screening in Women—Total	46.19%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	14.78%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.02%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	S
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.97%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	37.50%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	S
Prenatal and Postpartum Care—Postpartum Care	65.74%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.89%

Table 3.22—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—San Francisco County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	58.32%
Cervical Cancer Screening	57.28%
Chlamydia Screening in Women—Ages 16–20 Years	53.68%
Chlamydia Screening in Women—Ages 21–24 Years	59.43%
Chlamydia Screening in Women—Total	56.91%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	13.93%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	21.69%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.32%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.79%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	11.65%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	33.98%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	16.50%
Prenatal and Postpartum Care—Postpartum Care	67.80%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.75%

Table 3.23—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Santa Clara County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	56.11%
Cervical Cancer Screening	54.26%
Chlamydia Screening in Women—Ages 16–20 Years	56.93%
Chlamydia Screening in Women—Ages 21–24 Years	61.84%
Chlamydia Screening in Women—Total	59.41%

Measure	Reporting Year 2020 Rate
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	14.52%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	23.95%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.33%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.01%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	33.33%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	21.37%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	45.45%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	41.41%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	10.79%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	36.36%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	18.72%
Prenatal and Postpartum Care—Postpartum Care	77.37%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.13%

**Table 3.24—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Tulare County**

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	60.52%
Cervical Cancer Screening	66.94%
Chlamydia Screening in Women—Ages 16–20 Years	53.97%
Chlamydia Screening in Women—Ages 21–24 Years	71.40%
Chlamydia Screening in Women—Total	62.22%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.49%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.62%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.66%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.76%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.77%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	39.73%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	43.35%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.74%

Measure	Reporting Year 2020 Rate
Prenatal and Postpartum Care—Postpartum Care	82.97%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.24%

Assessment of Improvement Plans—Women's Health Domain

As previously stated, in April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Anthem Blue Cross conducted as part of its IP prior to April 2020.

The rate for the *Breast Cancer Screening—Total* measure was below the minimum performance level in reporting year 2019 in Alameda County, Contra Costa County, Fresno County, Kings County, Region 1, and Region 2. DHCS approved Anthem Blue Cross to conduct a SWOT analysis in place of PDSA cycles to improve its performance on the measure. The MCP reported that it implemented the following quality improvement strategies:

- In Alameda County, coordinated member outreach and breast cancer screening services with imaging providers that in turn communicated outreach and breast cancer screening results to participating federally qualified health centers (FQHCs).
  - Anthem Blue Cross reported learning that for this process to be successful, careful collaboration with the imaging provider and FQHC partners along with shared buy-in and commitment to meet the project goals is necessary.
- In Fresno County, facilitated provider education sessions using a lunch and learn format and conducted member outreach for participation in coordinated clinic days.

Anthem Blue Cross reported a delay in progress of the quality improvement strategies due to provider closures and temporary suspension of non-urgent medical services in response to the COVID-19 public health crisis.

DHCS did not hold MCPs accountable to meet the minimum performance level for the *Breast Cancer Screening—Total* measure in reporting year 2020; therefore, HSAG makes no assessment of Anthem Blue Cross' performance related to this measure.

Behavioral Health Domain

Table 3.25 through Table 3.36 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.25—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Alameda County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	51.99%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	35.46%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	36.56%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	6.72%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.39%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Table 3.26—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Contra Costa County

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

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	59.28%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	42.27%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	39.13%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	10.64%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.56%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%

Table 3.27—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Fresno County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	50.50%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	34.15%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	35.04%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	33.33%

Measure	Reporting Year 2020 Rate
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	8.60%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.88%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	1.86%

Table 3.28—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Kings County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	48.51%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	30.20%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	50.00%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.22%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%

Table 3.29—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Madera County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	41.86%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	30.23%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	53.13%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	1.45%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	2.14%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Table 3.30—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	54.19%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	37.12%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	46.50%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	64.71%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	3.16%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.64%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Table 3.31—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	55.65%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.05%

Measure	Reporting Year 2020 Rate
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	44.29%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	45.00%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	3.43%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.82%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Table 3.32—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Sacramento County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	54.63%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	38.88%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	30.13%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	38.30%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	6.85%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	5.49%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	10.07%

Table 3.33—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—San Benito County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	45.59%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	29.41%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	NA
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	7.73%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	S
Screening for Depression and Follow-Up Plan—Ages 65+ Years	NA

Table 3.34—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—San Francisco County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	55.81%

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	46.12%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	NA
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	10.94%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.61%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Table 3.35—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Santa Clara County

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

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	51.16%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	32.37%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	39.34%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	2.02%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.61%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	2.47%

Table 3.36—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Tulare County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	45.01%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	30.83%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	38.89%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	43.14%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	1.27%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.33%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.37 through Table 3.48 present the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.37—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Alameda County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.33%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	46.00
Asthma Medication Ratio—Total	59.25%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	42.09%
Comprehensive Diabetes Care—HbA1c Testing—Total	85.16%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.74%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	57.18%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.81%
Plan All-Cause Readmissions—Expected Readmissions—Total	10.06%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.07
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	8.01%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.38—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Contra Costa County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.33%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	44.56
Asthma Medication Ratio—Total	65.68%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	47.20%
Comprehensive Diabetes Care—HbA1c Testing—Total	82.73%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	12.11%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	57.18%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.08%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.40%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.18
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	13.37%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.39—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Fresno County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.33%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	44.15
Asthma Medication Ratio—Total	61.06%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	54.50%
Comprehensive Diabetes Care—HbA1c Testing—Total	85.16%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	8.79%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	54.74%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.24%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.40%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.98
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.30%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.40—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Kings County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.33%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	46.52
Asthma Medication Ratio—Total	70.00%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	48.91%
Comprehensive Diabetes Care—HbA1c Testing—Total	89.54%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	17.87%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	61.54%
HIV Viral Load Suppression—Ages 18–64 Years	NA
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.64%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.39%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.13
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.41—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Madera County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.33%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	43.67
Asthma Medication Ratio—Total	65.89%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	54.74%
Comprehensive Diabetes Care—HbA1c Testing—Total	89.54%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	13.20%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	63.26%
HIV Viral Load Suppression—Ages 18–64 Years	NA
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.20%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.33%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.88
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.42—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.33%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	43.75
Asthma Medication Ratio—Total	64.23%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	34.79%
Comprehensive Diabetes Care—HbA1c Testing—Total	82.48%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.36%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	63.02%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.80%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.65%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.02
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.20%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.43—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.33%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	52.13
Asthma Medication Ratio—Total	62.32%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	42.82%
Comprehensive Diabetes Care—HbA1c Testing—Total	85.40%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	15.79%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	55.47%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.51%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.40%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.91
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	7.51%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.44—Acute and Chronic Disease Management Domain Reporting Year 2020 Performance Measure Results Anthem Blue Cross—Sacramento County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.33%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	53.28
Asthma Medication Ratio—Total	58.38%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	33.82%
Comprehensive Diabetes Care—HbA1c Testing—Total	85.40%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.54%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	0.00%
Controlling High Blood Pressure—Total	54.26%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.47%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.58%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.99
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	10.03%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.45—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—San Benito County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.33%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	54.27
Asthma Medication Ratio—Total	68.35%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	40.34%
Comprehensive Diabetes Care—HbA1c Testing—Total	82.95%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	S
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	58.09%
HIV Viral Load Suppression—Ages 18–64 Years	NA
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA
Plan All-Cause Readmissions—Expected Readmissions—Total	NA
*Plan All-Cause Readmissions—O/E Ratio—Total***	NA
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	0.00%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

**Table 3.46—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—San Francisco County**

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.33%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	45.65
Asthma Medication Ratio—Total	46.74%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	28.71%
Comprehensive Diabetes Care—HbA1c Testing—Total	91.00%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.38%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	55.96%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.58%
Plan All-Cause Readmissions—Expected Readmissions—Total	10.30%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.12
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	13.59%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.47—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Santa Clara County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.33%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	41.38
Asthma Medication Ratio—Total	60.22%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	31.63%
Comprehensive Diabetes Care—HbA1c Testing—Total	83.21%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	6.84%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	56.20%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.58%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.44%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.91
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.48—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Anthem Blue Cross—Tulare County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.33%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	34.39
Asthma Medication Ratio—Total	65.82%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	33.82%
Comprehensive Diabetes Care—HbA1c Testing—Total	92.70%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	14.04%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	61.56%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.41%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.21%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.91
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	2.06%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Assessment of Improvement Plans—Acute and Chronic Disease Management Domain

As previously stated, in April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Anthem Blue Cross conducted as part of its IP prior to April 2020.

Based on reporting year 2019 performance measure results, DHCS required Anthem Blue Cross to submit IPs for the following measures within the Acute and Chronic Disease Management domain:

- *Asthma Medication Ratio—Total* in Alameda, Fresno, Sacramento, San Francisco, and Santa Clara counties
- *Comprehensive Diabetes Care—HbA1c Testing—Total* in Alameda County, Contra Costa County, Region 1, Region 2, San Benito County, and Santa Clara County

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of Anthem Blue Cross' performance related to measures within the Acute and Chronic Disease Management domain for which the MCP conducted IP quality improvement activities.

Asthma Medication Ratio

DHCS approved Anthem Blue Cross to conduct PDSA cycles to address the MCP's performance below the minimum performance level for the *Asthma Medication Ratio—Total* measure in Alameda, Fresno, Sacramento, San Francisco, and Santa Clara counties.

Anthem Blue Cross partnered with a large hospital system in Santa Clara County to test whether conducting telephonic member outreach would result in members attending appointments with their primary care providers (PCPs) and filling their asthma controller medication prescriptions. When conducting the outreach calls, Anthem Blue Cross and the provider partner used a call script that included educational messaging about the benefits of using controller medications and filling prescriptions, an offer to schedule PCP appointments following medication reconciliation, and an option for the member to receive a 90-day home delivery supply of asthma controller medications. The MCP reported learning that having a shared commitment with the provider partner's leadership strengthened the collaborative relationship and resulted in a more streamlined intervention that resulted in successful outreach efforts and more members receiving their controller medication refills.

Comprehensive Diabetes Care—HbA1c Testing

The rate for the *Comprehensive Diabetes Care—HbA1c Testing—Total* measure was below the minimum performance level in reporting year 2019 in Alameda County, Contra Costa County, Region 1, Region 2, San Benito County, and Santa Clara County. DHCS approved Anthem Blue Cross to conduct a SWOT analysis in place of PDSA cycles to improve its

performance on the measure. The MCP reported that it conducted multiple quality improvement activities within Region 1 and Region 2, including:

- Conducting provider training regarding using gap-in-care reports to adjust and improve member outreach process mapping.
- Partnering with a medical group that worked to capture and update member contact information from commercially available private databases to help reach non-engaged members.
- Connecting with local community partners likely to be in contact with the MCP's diabetic members as a way of reaching members in need of HbA1c testing.

Anthem Blue Cross indicated that COVID-19 impacted the normal operations of the provider partners, resulting in more telehealth engagement and restructuring of member preventive visits. The MCP reported learning the importance of communication and collaboration when redesigning quality improvement activities to improve performance on the *Comprehensive Diabetes Care—HbA1c Testing—Total* measure. The MCP noted the importance of updating COVID-19 information in the member portal, providing safe access to preventive services, and promoting the use of telehealth services among providers and members.

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, Anthem Blue Cross will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.49 through Table 3.60 present the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.49—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Alameda County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	89.85	41.59	Not Tested	46.00
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	88.61%	Not Comparable	88.51%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	79.37%	77.88%	1.49	77.90%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	82.50%	82.96%	-0.46	82.94%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	78.31%	81.46%	-3.15	81.28%
*Plan All-Cause Readmissions—Total***	11.45%	10.38%	1.07	10.81%

Table 3.50—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Contra Costa County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	78.45	41.60	Not Tested	44.56

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	NA	91.72%	Not Comparable	91.75%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	87.18%	83.05%	4.13	83.18%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	89.74%	86.98%	2.76	87.10%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	80.69%	83.38%	-2.69	83.21%
*Plan All-Cause Readmissions— Total***	NA	11.26%	Not Comparable	11.08%

Table 3.51—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Fresno County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	71.44	42.14	Not Tested	44.15
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	93.16%	Not Comparable	93.17%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	86.51%	84.71%	1.80	84.76%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	86.70%	84.47%	2.23	84.56%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	84.73%	80.81%	3.92	80.98%
*Plan All-Cause Readmissions—Total***	11.35%	8.41%	2.94	9.24%

Table 3.52—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Kings County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	79.79	44.54	Not Tested	46.52
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	95.16%	Not Comparable	95.19%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	87.50%	86.49%	1.01	86.52%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	90.70%	88.25%	2.45	88.35%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	83.00%	86.11%	-3.11	86.01%
*Plan All-Cause Readmissions—Total***	NA	8.68%	Not Comparable	10.64%

Table 3.53—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Madera County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	69.88	42.44	Not Tested	43.67
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	95.28%	Not Comparable	95.30%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	NA	91.39%	Not Comparable	91.48%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	97.83%	93.94%	3.89	94.02%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	95.65%	90.77%	4.88	90.90%
*Plan All-Cause Readmissions—Total***	NA	7.66%	Not Comparable	8.20%

Table 3.54—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	77.61	41.05	Not Tested	43.75
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	95.11%	Not Comparable	95.15%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	87.60%	88.13%	-0.53	88.12%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	92.81%	89.58%	3.23	89.66%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	86.14%	86.73%	-0.59	86.71%
*Plan All-Cause Readmissions—Total***	10.81%	9.31%	1.50	9.80%

Table 3.55—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	82.66	49.85	Not Tested	52.13

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	NA	94.10%	Not Comparable	94.06%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	82.39%	83.70%	-1.31	83.68%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	82.53%	84.58%	-2.05	84.51%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	80.52%	83.56%	-3.04	83.46%
*Plan All-Cause Readmissions— Total***	11.84%	7.18%	4.66	8.51%

Table 3.56—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Sacramento County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	82.86	50.16	Not Tested	53.28
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	92.49%	Not Comparable	92.54%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	84.05%	83.04%	1.01	83.06%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	85.41%	82.68%	2.73	82.80%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	81.30%	80.94%	0.36	80.96%
*Plan All-Cause Readmissions—Total***	11.91%	8.09%	3.82	9.47%

Table 3.57—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—San Benito County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	43.61	54.42	Not Tested	54.27
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	93.72%	Not Comparable	93.75%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	NA	84.18%	Not Comparable	84.35%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	NA	84.93%	Not Comparable	84.80%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	NA	82.18%	Not Comparable	82.29%
*Plan All-Cause Readmissions—Total***	NA	NA	Not Comparable	NA

Table 3.58—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—San Francisco County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	87.35	36.80	Not Tested	45.65
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	92.81%	Not Comparable	92.91%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	NA	84.93%	Not Comparable	85.15%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	83.33%	86.71%	-3.38	86.56%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	75.86%	87.02%	-11.16	86.27%
*Plan All-Cause Readmissions—Total***	12.74%	10.46%	2.28	11.58%

Table 3.59—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Santa Clara County

[green] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

[red] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	52.68	40.34	Not Tested	41.38
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	93.44%	Not Comparable	93.36%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	80.56%	85.32%	-4.76	85.24%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	76.82%	87.50%	-10.68	87.12%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	73.63%	83.81%	-10.18	83.38%
*Plan All-Cause Readmissions—Total***	6.35%	9.04%	-2.69	8.58%

Table 3.60—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Anthem Blue Cross—Tulare County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	68.72	32.47	Not Tested	34.39
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	97.03%	Not Comparable	97.06%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	92.34%	90.91%	1.43	90.95%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	92.88%	91.87%	1.01	91.90%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	90.66%	90.33%	0.33	90.34%
*Plan All-Cause Readmissions—Total***	10.26%	7.73%	2.53	8.41%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that Anthem Blue Cross stratified by the SPD and non-SPD populations and for which HSAG could compare reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results:

- In Fresno County, the reporting year 2020 SPD rate was significantly better than the reporting year 2020 non-SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years* measure.
- Members ages 7 to 11 years in Santa Clara County and 12 to 19 years in San Francisco and Santa Clara counties in the SPD population had significantly fewer instances of a visit with a PCP during the measurement year than members in these age groups in the non-SPD population in reporting year 2020. The significant differences may be attributed to members ages 7 to 19 in the SPD population in these counties choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from PCPs.
- In reporting year 2020, the SPD population had a significantly higher hospital readmissions rate than the non-SPD population in Fresno County, Region 2, and Sacramento County. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Anthem Blue Cross' participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Anthem Blue Cross report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the reporting year 2020 rates for each required MLTSSP performance measure. Table 4.1 presents reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 4.1—Reporting Year 2020 MLTSSP Performance Measure Results
Anthem Blue Cross—Santa Clara County

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

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	88.49
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA
Plan All-Cause Readmissions—Expected Readmissions—Total	NA
*Plan All-Cause Readmissions—O/E Ratio—Total***	NA

5. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, Anthem Blue Cross submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, Anthem Blue Cross initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

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

Table 5.1 provides the SMART Aim measure results reported by the MCP for its *Asthma Medication Ratio* Disparity PIP.

Table 5.1—Anthem Blue Cross *Asthma Medication Ratio* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of controller medication refills among a cohort of 60 non-compliant African Americans 5 to 64 years of age residing in Alameda County who have Provider Network A[6] as their PCP	13.6%	16.4%	No

[6] Provider network name removed for confidentiality.

Table 5.2 presents a description of the intervention that Anthem Blue Cross tested for its *Asthma Medication Ratio* Disparity PIP. The table also indicates the failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.2—Anthem Blue Cross *Asthma Medication Ratio* Disparity PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Providing one-on-one telephonic health education counseling sessions to encourage members to take proactive roles in controlling their asthma	♦ Member not provided with information about the importance of asthma self-management ♦ Member not interested in understanding the information provided ♦ Clinic staff members do not understand how to counsel on asthma self-management	Abandon

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Anthem Blue Cross' *Asthma Medication Ratio* Disparity PIP. In the modules, Anthem Blue Cross documented that it tested the one-on-one telephonic health education counseling intervention in three stages from November 2018 through May 2019. Due to significant challenges in reaching members telephonically and coordinating with the local clinics to reach out to the members, Anthem Blue Cross decided to abandon this intervention. Despite Anthem Blue Cross' efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned Anthem Blue Cross' *Asthma Medication Ratio* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on Anthem Blue Cross' reporting year 2017 performance measure results, the MCP selected postpartum care as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure results as reported by the MCP for its *Postpartum Care* PIP.

Table 5.3—Anthem Blue Cross *Postpartum Care* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of postpartum care visits among women who reside in Kings County	40.12%	55.47%	No

Table 5.4 presents a description of the intervention that Anthem Blue Cross tested for its *Postpartum Care* PIP. The table also indicates the failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.4—Anthem Blue Cross *Postpartum Care* PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Counseling and providing education to members during the prenatal period that emphasizes the importance of postpartum care	♦ Provider does not reinforce postpartum exam education ♦ Women are not interested in understanding the education provided ♦ Current educational materials are not suitable	Adopt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Anthem Blue Cross' *Postpartum Care* PIP. In the modules, Anthem Blue Cross documented that it began testing the intervention (counseling and providing education on the importance of postpartum care) in June 2019. Based on the intervention effectiveness measure data, Anthem Blue Cross documented that of the 116 members who delivered live births, 104 received education, 65 of whom completed a postpartum visit. The MCP determined to adopt the intervention. While Anthem Blue Cross achieved the SMART Aim goal, it appears that the MCP did not calculate the monthly SMART Aim measure rates in alignment with the methodology documented in Module 2 and in accordance with the rolling 12-month measurement methodology.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned Anthem Blue Cross' *Postpartum Care* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, Anthem Blue Cross identified well-child visits among African-American children in Sacramento County as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 through 3 for the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP. Anthem Blue Cross met all validation criteria for all three modules in its initial submissions.

Table 5.5 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP.

Table 5.5—Anthem Blue Cross *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of well-child visits among African American members ages 3 to 6 living in Sacramento County assigned to Provider A[7]	47.68%	72.87%

Table 5.6 presents a description of the intervention that Anthem Blue Cross selected to test for its *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP. The table also indicates the failure mode that the intervention aims to address.

[7] Provider name removed for confidentiality.

Table 5.6—Anthem Blue Cross *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP Intervention Testing

Intervention	Failure Mode Addressed
Host monthly, or more frequent, Well-Child Clinic Day events at Provider A and provide a gift card incentive to those eligible members who complete the visit and post-visit survey	Well-child visit appointments are inconvenient for parents to schedule

While Anthem Blue Cross advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, Anthem Blue Cross selected childhood immunizations as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 through 3 for the MCP's *Childhood Immunizations—Combination 10* PIP. HSAG determined that Anthem Blue Cross met all required validation criteria for modules 1 and 2 upon initial review; however, due to Anthem Blue Cross needing to remove one of the intervention test sites, the MCP resubmitted modules 1 and 2 with updated information along with its Module 3 initial submission. HSAG provided validation findings for the modules 1 and 2 resubmissions and Module 3 initial submission when DHCS determined to end the 2019–21 PIPs; therefore, Anthem Blue Cross did not have an opportunity to incorporate HSAG's feedback into modules 1 through 3.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, Anthem Blue Cross identified an intervention that it can adopt to improve postpartum visits among its members who recently delivered.

Opportunities for Improvement—Performance Improvement Projects

Anthem Blue Cross has the opportunity to monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Postpartum Care* PIP. Anthem Blue Cross also has the opportunity to apply the lessons learned from the 2017–19 *Postpartum Care* and *Asthma Medication Ratio* Disparity PIPs to facilitate improvement for future PIPs and to strengthen other quality improvement efforts.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 (“Validation of Network Adequacy”) provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS’ process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

As part of NCQA's accreditation requirements, Anthem Blue Cross submits accreditation reports to NCQA that contain information similar to what DHCS requires for the PNA report; therefore, DHCS approved Anthem Blue Cross to submit sections of the MCP's NCQA accreditation reports to meet the PNA report requirements. Anthem Blue Cross submitted the MCP's final PNA report to DHCS on July 21, 2020, and DHCS notified the MCP via email on August 5, 2020, that DHCS approved the report as submitted. While Anthem Blue Cross submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from Anthem Blue Cross' July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of Anthem Blue Cross' self-reported actions.

Table 8.1—Anthem Blue Cross' Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP fully resolves all findings from the 2017 and 2018 A&I Medical Audits.	Anthem Blue Cross continues to work with DHCS on closing out the CAPs that are in place for the 2017 and 2018 A&I Medical Audits.
2. Determine whether current improvement strategies related to the following measures with declining rates or rates below the minimum performance levels in reporting year 2019 need to be modified or expanded to improve the MCP's performance:	
♦ *Asthma Medication Ratio* in Alameda, Fresno, Sacramento, San Francisco, and Santa Clara counties (The rates for this measure were also below the minimum performance level in reporting year 2018 for all listed reporting units except Santa Clara County.)	Based on reporting year 2019 (measurement year 2018) HEDIS results, Anthem Blue Cross was below the minimum performance level for the *Asthma Medication Ratio* measure in Alameda County; additional analysis showed a disparity for Anthem Blue Cross members who identify as Black. In collaboration with a local FQHC, Anthem Blue Cross designed and tested a PIP member education intervention on self-management and the importance of controller medication refills. Intervention effectiveness was measured by way of pre- and post-tests and count of pharmacy refills. The final PIP modules 4 and 5 were submitted on September 20, 2019. Final data analysis

2018–19 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	indicated the intervention was effective, with an increase in the rate of controller medication refills. In fourth quarter 2019, Anthem Blue Cross began a PDSA cycle for the *Asthma Medication Ratio* measure in Santa Clara County. In consultation with DHCS, Anthem Blue Cross partnered with a large county-operated health system to improve asthma medication management between its PCPs and pharmacies. While the quality improvement project was compliant with DHCS submission requirements, given the COVID-19 public health emergency, the PDSA cycle ended before results could be evaluated. The clinic system is on the front lines of the COVID-19 public health emergency and declined to resume the PDSA cycle in the near future. In 2019, Anthem Blue Cross created an Asthma Medication Ratio Workgroup to help improve San Francisco County's *Asthma Medication Ratio* measure rate. The following interventions were identified and implemented: ♦ Member Outreach: Anthem Blue Cross educated members on controller and rescue inhalers, confirmed the members were engaged in care with their PCP, and addressed any potential barriers to the members refilling their prescriptions. ♦ Medical Record Review: Anthem Blue Cross targeted high-volume, low-performing providers for the *Asthma Medication Ratio* measure, requested and reviewed medical records to complete a gap analysis on controller asthma medications prescribed but not filled, and followed up with and educated the member, as appropriate. ♦ Provider Assessment: Anthem Blue Cross discussed findings from the medical record review with the providers and educated providers on gaps in care and diagnosis codes (related to member inclusion in the denominator).

2018–19 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	An *Asthma Medication Ratio* measure tip sheet was created and shared with providers on asthma medications, use of controllers versus rescue inhalers, how to refer members for education support, and best practices on improving the *Asthma Medication Ratio* measure rates.
♦ *Breast Cancer Screening* in Alameda County, Contra Costa County, Fresno County, Kings County, Region 1, and Region 2 (The rates for this measure were also below the minimum performance level in reporting year 2018 for all listed reporting units except Alameda County.)	In fourth quarter 2019, Anthem Blue Cross began SWOT cycles (Strengths, Weaknesses, Opportunities, Threats) to improve *Breast Cancer Screening* measure rates in Alameda and Fresno counties. In Alameda County, Anthem Blue Cross piloted a breast cancer screening standing order process in partnership with two local FQHCs and imaging centers with which they have referral relationships. In Fresno County, Anthem Blue Cross piloted a breast cancer screening referral intervention with a local FQHC, and eventually a large imaging center provider. While the SWOT projects were demonstrating results and were compliant with DHCS submission requirements, due to the COVID-19 public health emergency and DHCS guidance, the interventions ended prior to completion. Anthem Blue Cross is in ongoing conversations with the FQHC to resume breast cancer screening standing orders as public health emergency restrictions are lifted. Two of the FQHCs in Alameda County agreed to move forward with the standing order intervention if COVID-19 precautionary procedures are adopted by the imaging center. Anthem Blue Cross is waiting for the imaging center to confirm it is willing and able to meet the requirements. Additionally, one of the Alameda County FQHCs with a health center in Contra Costa County is piloting the intervention with the goal of adopting the standing orders in other Contra Costa County clinics. In third and fourth quarters 2019, Anthem Blue Cross coordinated breast cancer screening days with a mobile mammography vendor and FQHCs in Fresno County, Region 1, and Region 2. Members were

2018–19 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	awarded gift cards for completing the recommended screening. Anthem Blue Cross executed a contract with a mobile mammography vendor, effective January 1, 2020, to expand member access to breast cancer screenings. Anthem Blue Cross partners with the mobile mammography vendor and contracted health centers to coordinate and complete breast cancer screening clinic days and awards members with a gift card for completing the recommended screening. Due to the COVID-19 public health emergency and shelter in place mandate, the intervention was put on hold through June 2020. Anthem Blue Cross will resume clinic days in select counties starting July 2020.
♦ *Childhood Immunization Status—Combination 3* in Region 2, Sacramento County, San Benito County, and Tulare County (The rates for this measure were also below the minimum performance level in reporting year 2018 for Region 2 and San Benito County.)	In fourth quarter 2019, Anthem Blue Cross submitted a Priority Child and Adolescent PIP topic proposal to improve the *Childhood Immunization Status—Combination 10* measure rate in Region 2. Anthem Blue Cross subsequently submitted modules 1, 2, and 3, and established relationships with PIP providers. The target intervention start date was July 1, 2020. Due to the COVID-19 public health emergency and DHCS guidance, the PIP ended prior to implementation. Engaging providers in electronic data transmission with the California Immunization Registry enhances immunization data quality and promotes ready access to a member's comprehensive immunization history. In 2019, Anthem Blue Cross provided 11 health centers with grants to purchase an EHR interface to automate data exchange with the California Immunization Registry. Under the "California Immunization Registry Catch Up" pilot program in Sacramento County and Region 2, Anthem Blue Cross partnered with a provider medical group (PMG) and select health centers with very low *Childhood Immunization Status—Combination 10*

2018–19 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	measure rates to manually enter historical immunizations from the medical record into the California Immunization Registry.
♦ *Comprehensive Diabetes Care—HbA1c Testing* in Alameda County, Contra Costa County, Region 1, Region 2, San Benito County, and Santa Clara County (The rates for this measure have been below the minimum performance levels for more than three consecutive years in San Benito County.)	In fourth quarter 2019, Anthem Blue Cross began SWOT cycles to improve *Comprehensive Diabetes Care—HbA1c Testing* measure rates in Region 1 and Region 2. Anthem Blue Cross partnered with FQHCs in each region and provided education on using the gap-in-care report as a call list to outreach members in need of an HbA1c test. The SWOT projects met DHCS submission requirements and were demonstrating results; however, due to the COVID-19 public health emergency, the intervention ended prior to results being evaluated. Anthem Blue Cross partnered with a vendor in third and fourth quarters 2019 to administer in-home A1c testing to members with diabetes who had not yet received an HbA1c test. By the end of the year, 245 members statewide received an HbA1c test.

2018–19 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
♦ *Immunizations for Adolescents—Combination 2* in Region 1 and San Benito County	In fourth quarter 2019, Anthem Blue Cross began a PDSA cycle to improve *Immunizations for Adolescents—Combination 2* measure rates in San Benito County. Anthem Blue Cross partnered with a large FQHC to implement the following interventions: ♦ Dedicating staff members to improve member outreach ♦ Creating a HEDIS dashboard to support outreach efforts ♦ Modifying clinic protocols to reduce barriers to care While the PDSA cycle met DHCS submission requirements, due to the COVID-19 public health emergency and DHCS guidance, it ended before results could be evaluated. Engaging providers in electronic data transmission with the California Immunization Registry enhances immunization data quality and promotes ready access to a member's comprehensive immunization history. In 2019, Anthem Blue Cross provided grants to 11 health centers to purchase an EHR interface to automate data exchange with the California Immunization Registry.
♦ *Well-Child Visits in the Third, Fourth, Fifth, and* Sixth *Years of Life* in Alameda, Kings, San Benito, and Tulare counties	In third quarter 2019, Anthem Blue Cross submitted a Health Equity PIP topic proposal to reduce disparities for well-child visits in Sacramento County and increase the rate at which members who identify as Black received the services. Anthem Blue Cross subsequently submitted modules 1, 2 and 3, and developed an excellent partnership with the participating PIP provider. The target intervention implementation date was July 1, 2020. Due to the COVID-19 public health emergency and DHCS guidance, the PIP process ended prior to the start date. In 2019, Anthem Blue Cross partnered with a pediatric PMG based in Alameda County to host quarterly workshops for providers. The sessions included

2018–19 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	education on the importance of well-child visits and related best practices. In June 2020, Anthem Blue Cross received buy-in from providers in Alameda County to host virtual clinic days for well-child visits. As part of Anthem Blue Cross' Clinic Pay-for-Performance (CP4P) program, prospective incentive payments have been made to select high-volume providers (includes Alameda, Kings, and Tulare counties) to be used for improvement activities to improve well-child visit rates. Low- scoring measures, including *Well-Child Visits in the Third, Fourth, Fifth, and* Sixth *Years of Life*, are included in the program, and providers are required to develop quality improvement plans addressing the measures. An example of an improvement activity includes the use of text messaging platforms to inform and remind members of the importance of well-child visits.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Anthem Blue Cross' self-reported actions in Table 8.1 and determined that the MCP adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. Anthem Blue Cross described in detail actions taken during the review period, results from the MCP's assessment of declining performance and performance below the minimum performance levels, and steps the MCP intends to take moving forward. Anthem Blue Cross described specific interventions the MCP implemented to improve performance to above the minimum performance levels or prevent further decline in performance, including:

- Conducting member education, care gap analyses, and provider education to improve performance on the *Asthma Medication Ratio—Total* measure.
- Implementing standing orders for breast cancer screening and conducting breast cancer screening clinic days using a mobile mammography vendor.
- Providing grants to health centers to purchase an EHR interface to allow them to exchange immunization data with the California Immunization Registry.

- Partnering with a vendor to administer in-home HbA1c tests.
- Providing incentive payments to providers to use for activities that support improving well-child visit rates.

2019–20 Recommendations

Based on the overall assessment of Anthem Blue Cross' delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Postpartum Care* PIP.
- Apply the lessons learned from the 2017–19 *Postpartum Care* DHCS-priority PIP and *Asthma Medication Ratio* Disparity PIPs to facilitate improvement for future PIPs and to strengthen other quality improvement efforts.

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

Appendix F:
Performance Evaluation Report
Blue Shield of California Promise Health Plan

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Blue Shield of California Promise Health Plan (prior to January 1, 2019, known as Care1st Health Plan and referred to in this report as "Blue Shield Promise" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in Blue Shield Promise's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific

activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

Blue Shield Promise is a full-scope MCP delivering services to its members under a Geographic Managed Care (GMC) model. Although the GMC model operates in both San Diego and Sacramento counties, Blue Shield Promise only operates in San Diego County. In the GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county). In addition to Blue Shield Promise, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Community Health Group Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser SoCal
- Molina Healthcare of California
- UnitedHealthcare Community Plan

Blue Shield Promise became operational in San Diego County to provide MCMC services effective February 2006. As of June 2020, Blue Shield Promise had 84,524 members.[1] This represents 12 percent of the beneficiaries enrolled in San Diego County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Blue Shield Promise.

Table 2.1 summarizes the results and status of the 2019 on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Blue Shield Promise. A&I conducted the audits from January 22, 2019, through January 25, 2019. DHCS issued the final closeout letter on November 6, 2020, which is outside the review period for this report; however, HSAG includes the information from the letter because it reflects full resolution of the findings from the 2019 A&I Medical Audit.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Blue Shield Promise
Audit Review Period: January 1, 2018, through December 31, 2018

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	Corrective action plan (CAP) imposed and findings in this category rectified.
Case Management and Coordination of Care	Yes	CAP imposed and findings in this category rectified.
Access and Availability of Care	No	No findings.
Member's Rights	Yes	CAP imposed and findings in this category rectified.
Quality Management	Yes	CAP imposed and findings in this category rectified.
Administrative and Organizational Capacity	Yes	CAP imposed and findings in this category rectified.
State Supported Services	No	No findings.

Table 2.2 summarizes the results and status of the 2020 on-site DHCS A&I Medical and State Supported Services Audits of Blue Shield Promise. A&I conducted the audits from January 27, 2020, through February 6, 2020. During the audits, A&I reviewed documentation to determine Blue Shield Promise's compliance with the DHCS contract requirements and actions taken by the MCP to resolve the 2019 audit findings. DHCS issued the final closeout letter on November 5, 2020, which is outside the review period for this report; however, HSAG includes the information from the letter because it reflects full resolution of the findings from the 2020 A&I Medical Audit.

Table 2.2—DHCS A&I Medical and State Supported Services Audits of Blue Shield Promise
Audit Review Period: January 1, 2019, through December 31, 2019

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

Strengths—Compliance Reviews

During the 2019 and 2020 A&I Medical and State Supported Services Audits of Blue Shield Promise, A&I identified no findings in the Access and Availability of Care and State Supported Services categories. Additionally, in response to the CAPs from the 2019 and 2020 A&I Medical Audits of Blue Shield Promise, the MCP provided documentation to DHCS that resulted in DHCS closing both CAPs. Blue Shield Promise's documentation reflected changes to policies and procedures to ensure the MCP is compliant with DHCS' standards within the Utilization Management, Case Management and Coordination of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity categories.

Opportunities for Improvement—Compliance Reviews

Blue Shield Promise has no outstanding findings from the 2019 or 2020 A&I Medical Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures Blue Shield Promise chose to report using one or both of these two options.

[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- ♦ Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- ♦ Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of Blue Shield Promise, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Blue Shield of California Promise Health Plan* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for Blue Shield Promise's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Blue Shield Promise—San Diego County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	45.01%
Childhood Immunization Status—Combination 10	40.39%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	82.18%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	68.30%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	75.58%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	71.71%
Developmental Screening in the First Three Years of Life—Total	37.42%
Immunizations for Adolescents—Combination 2	39.17%

Measure	Reporting Year 2020 Rate
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	91.15%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	40.18%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.75%

Assessment of Improvement Plans—Children's Health Domain

In April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Blue Shield Promise conducted as part of its IP prior to April 2020.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure was below the minimum performance level in reporting year 2019. DHCS approved Blue Shield Promise to conduct a *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP in place of conducting PDSA cycles to improve the MCP's performance on this measure. HSAG includes a summary of Blue Shield Promise's progress on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP in Section 5 of this report ("Performance Improvement Projects").

DHCS did not hold MCP's accountable to meet the minimum performance level for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in reporting year 2020; therefore, HSAG makes no assessment of Blue Shield Promise's performance related to this measure.

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Blue Shield Promise—San Diego County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	53.80%
Cervical Cancer Screening	57.95%
Chlamydia Screening in Women—Ages 16–20 Years	65.26%
Chlamydia Screening in Women—Ages 21–24 Years	65.84%
Chlamydia Screening in Women—Total	65.59%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.09%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	24.13%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.79%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.31%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	10.20%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	37.04%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	34.38%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.54%
Prenatal and Postpartum Care—Postpartum Care	77.86%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	94.89%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Blue Shield Promise—San Diego County

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

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	61.77%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	46.90%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	46.88%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	17.99%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	14.10%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	14.97%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Blue Shield Promise—San Diego County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	98.11%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	43.73
Asthma Medication Ratio—Total	51.52%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	35.52%
Comprehensive Diabetes Care—HbA1c Testing—Total	93.92%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.69%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	12.90%
Controlling High Blood Pressure—Total	66.05%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	0.00%
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.80%
Plan All-Cause Readmissions—Expected Readmissions—Total	10.13%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.77
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	7.01%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S

Assessment of Improvement Plans—Acute and Chronic Disease Management Domain

As previously stated, in April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Blue Shield Promise conducted as part of its IP prior to April 2020.

The rate for the *Asthma Medication Ratio—Total* measure was below the minimum performance level in reporting year 2019. DHCS approved Blue Shield Promise to conduct PDSA cycles to address the MCP's performance below the minimum performance level for this measure.

Blue Shield Promise tested whether conducting outreach to non-compliant members would result in these members scheduling an appointment with their primary care providers (PCPs) and refilling their asthma medications. The MCP conducted outreach via live phone calls, interactive voice response calls, and mailers to encourage targeted members to schedule their PCP appointments. During the appointment, the PCP provided the members with education about asthma and information about the member incentive for asthma medication use and refill compliance. Blue Shield Promise indicated learning that timely receipt of reports showing which members received the incentive would have allowed the MCP to follow up with members who had not redeemed the incentive to provide asthma medication education prior to the incentive program ending.

DHCS did not hold MCPs accountable to meet the minimum performance level for the *Asthma Medication Ratio—Total* measure in reporting year 2020; therefore, HSAG makes no assessment of Blue Shield Promise's performance related to this measure.

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, Blue Shield Promise will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Blue Shield Promise—San Diego County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	80.60	39.84	Not Tested	43.73

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	NA	82.37%	Not Comparable	82.18%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	67.00%	68.33%	-1.33	68.30%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	72.31%	75.71%	-3.40	75.58%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	68.13%	71.85%	-3.72	71.71%
*Plan All-Cause Readmissions— Total***	10.62%	6.61%	4.01	7.80%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that Blue Shield Promise stratified by the SPD and non-SPD populations and for which HSAG could compare the reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed that the SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Blue Shield Promise's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Blue Shield Promise report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the reporting year 2020 rates for each required MLTSSP performance measure. Table 4.1 presents reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 4.1—Reporting Year 2020 MLTSSP Performance Measure Results
Blue Shield Promise—San Diego County

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	82.82
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.96%
Plan All-Cause Readmissions—Expected Readmissions—Total	13.51%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.81

5. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, Blue Shield Promise submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, Blue Shield Promise initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

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

Table 5.1 provides the SMART Aim measure results reported by the MCP for its *Childhood Immunization Status—Combination 3* Disparity PIP.

Table 5.1—Blue Shield Promise *Childhood Immunization Status—Combination 3* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of non-Hispanic members 2 years of age residing in San Diego County who receive appropriate immunizations	54.9%	74.0%	No

Table 5.2 presents a description of the intervention that Blue Shield Promise tested for its *Childhood Immunization Status—Combination 3* Disparity PIP. The table also indicates the failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.2—Blue Shield Promise *Childhood Immunization Status—Combination 3* Disparity PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Conduct a text message campaign to send a standardized and approved text message, translated into 22 languages, to parents/guardians of children eligible for childhood immunizations	♦ Parents/guardians do not return provider offices' calls even if the offices leave voice messages ♦ Parents/guardians may forget the appointments ♦ Parents/guardians may realize the appointment dates are inconvenient	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Blue Shield Promise's *Childhood Immunization Status—Combination 3* Disparity PIP. The MCP tested a text message campaign to encourage parents/guardians of non-Hispanic members under 2 years of age who are due for their immunizations to set up immunization appointments. Despite Blue Shield Promise's efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned Blue Shield Promise's *Childhood Immunization Status—Combination 3* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on Blue Shield Promise's reporting year 2017 performance measure results, the MCP selected well-child visits among members ages 3 to 6 as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure results as reported by the MCP for its *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP.

Table 5.3—Blue Shield Promise *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of well-care visits for children ages 3 to 6 years at Health Center A[6]	62.05%	68.30%	No

Table 5.4 presents a description of the intervention that Blue Shield Promise tested for its *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. The table also indicates the failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.4—Blue Shield Promise *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Conduct a text message campaign to send a standardized and approved text message, translated into 22 languages, to parents/guardians of children eligible for well-child visits	♦ Not all members are successfully contacted to remind them of the well-child care visits ♦ Parents/guardians do not return provider offices' calls even if offices leave voice messages ♦ Parents/guardians do not show up at the appointments	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Blue Shield Promise's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. The MCP tested a text message campaign to encourage parents/guardians of members 3 to 6 years of age in need of annual well-child visits to schedule their well-child visit appointments. Despite Blue Shield Promise's efforts, the MCP did not achieve the SMART Aim goal.

[6] Health center name removed for confidentiality.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned Blue Shield Promise's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, Blue Shield Promise determined to continue its focus on childhood immunizations among non-Hispanic children for its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 through 3 for the MCP's *Childhood Immunization Status—Combination 3* Health Equity PIP. Upon initial review of the modules, HSAG determined that Blue Shield Promise met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.
- Including all required components of the SMART Aim run chart.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Linking logically the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.
- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.
- Ensuring that the intervention effectiveness measure was appropriate for the intervention.

After receiving technical assistance from HSAG, Blue Shield Promise incorporated HSAG's feedback into modules 1 through 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 through 3.

Table 5.5 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the MCP's *Childhood Immunization Status—Combination 3* Health Equity PIP.

Table 5.5—Blue Shield Promise *Childhood Immunization Status—Combination 3* Health Equity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of non-Hispanic members 2 years of age residing in San Diego County who receive the appropriate immunizations according to the *Childhood Immunization Status—Combination 3* measure requirements	58.98%	74.00%

Table 5.6 presents a description of the intervention that Blue Shield Promise selected to test for its *Childhood Immunization Status—Combination 3* Health Equity PIP. The table also indicates the failure mode that the intervention aims to address.

Table 5.6—Blue Shield Promise *Childhood Immunization Status—Combination 3* Health Equity PIP Intervention Testing

Intervention	Failure Mode Addressed
Implement member gift card incentive program to encourage parents/guardians of eligible non-Hispanic members to ensure the members receive appropriate immunizations according to the *Childhood Immunization Status—Combination 3* measure schedule	Parents/guardians may not see the urgency of bringing eligible members to the clinic for the preventive service

While Blue Shield Promise advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, Blue Shield Promise determined to continue to focus on well-child visits among members ages 3 to 6 for its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 through 3 for the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. Upon initial review of the modules, HSAG determined that Blue Shield Promise met all Module 2 validation criteria. Blue Shield Promise met some required validation criteria for modules 1 and 3; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.

- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Ensuring that the intervention effectiveness measure was appropriate for the intervention.

After receiving technical assistance from HSAG, Blue Shield Promise incorporated HSAG's feedback into modules 1 and 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 3.

Table 5.7 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP.

Table 5.7—Blue Shield Promise *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of well-child visits in the third, fourth, fifth, and sixth years of life among members assigned to Health Center A[7]	64.8%	74.0%

Table 5.8 presents a description of the intervention that Blue Shield Promise selected to test for its *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. The table also indicates the failure mode that the intervention aims to address.

Table 5.8—Blue Shield Promise *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP Intervention Testing

Intervention	Failure Mode Addressed
Implement member gift card incentive program to encourage parents/guardians of eligible members to schedule and complete members' well-child visits	Parents/guardians and members do not show up to the scheduled appointments

While Blue Shield Promise advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

[7] Health center name removed for confidentiality.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, Blue Shield Promise identified interventions that it can adapt to improve adherence to immunizations and well-child visits for children.

Opportunities for Improvement—Performance Improvement Projects

Blue Shield Promise has the opportunity to monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs. The MCP should apply lessons learned from these PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

Blue Shield Promise submitted the MCP's final PNA report to DHCS on August 17, 2020, and DHCS notified the MCP via email on the same date that DHCS approved the report as submitted. While Blue Shield Promise submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from Blue Shield Promise's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of Blue Shield Promise's self-reported actions.

Table 8.1—Blue Shield Promise's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. To address the MCP's continued performance below the minimum performance level for the *Asthma Medication Ratio* measure, assess whether current improvement strategies need to be changed or expanded to ensure that beneficiaries ages 5 to 64 who are identified as having persistent asthma have a ratio of controller medications to total asthma medications of 0.50 or greater.	In September 2019, Blue Shield Promise completed the Plan portion of the required PDSA cycle. Blue Shield Promise identified San Diego Family Care as the continued narrowed focus group. The SMART objective for the PDSA cycle was that by December 31, 2020, the rate for the *Asthma Medication Ratio* measure would increase from the current rate of 45.45 percent to 67.00 percent for San Diego Family Care located in San Diego County. The identified intervention was to offer members a gift card incentive through a program called Healthy Rewards. Healthy Rewards is a vendor-run incentive program offered to members for measures identified by Blue Shield Promise. Because the incentive is considered a "high touch" member incentive, Blue Shield Promise determined it would be necessary to involve the narrowed focus group to help with communication and outreach.

2018–19 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	The planned intervention ran from October 1, 2019, through December 31, 2019. Members who were eligible for the *Asthma Medication Ratio* measure incentive received a $10 gift card for each refill of an eligible prescription up to a total of three times. The vendor conducted initial outreach to eligible members via interactive voice response system, email, and physical mailers. In addition, San Diego Family Care provided an additional level of personal outreach via phone calls to its members to advise them of the available incentive and provide education on the importance of refilling prescriptions. It was predicted that the additional layer of outreach done by the provider group would encourage members to refill medications and redeem the incentive. At the conclusion of the intervention testing, it was determined that the intervention did not have any impact on rate improvement. In January 2020, DHCS required Blue Shield Promise to complete another PDSA cycle, and Blue Shield Promise chose to “adapt” the intervention and pilot an in-person gift card incentive for members who refill their medications. The goal of the adapted intervention was to provide members immediate access to the gift card incentive upon proof of refill and to hopefully encourage patients to visit their PCPs. Although Blue Shield Promise received DHCS’ approval to move forward with the gift card incentive, in March 2020, DHCS suspended all PDSA cycle submission requirements due to COVID-19, and intervention testing therefore came to a halt. Blue Shield Promise will continue to work to improve the *Asthma Medication Ratio* measure and all other MCAS measure rates

2018–19 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	and will work with the individual needs of the clinics/groups. In addition to the PDSA cycle work, Blue Shield Promise conducted member outreach for the *Asthma Medication Ratio* measure to educate and remind members to refill their asthma medication. These calls were conducted by an internal outreach team and included all members in the *Asthma Medication Ratio* measure denominator. The calls are continuing throughout 2020, although there has been some impact due to COVID-19.
2. To improve the MCP's performance to above the minimum performance level for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure; determine the factors preventing beneficiaries ages 3 to 6 from being seen for one or more well-child visits with a PCP during the measurement year; and identify strategies to address the factors.	In November 2019, Blue Shield Promise completed the Module 1 submission for its *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP and chose Family Health Centers of San Diego as the narrowed focus group for implementing an intervention to improve the rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. The SMART Aim goal for the PIP was that by June 30, 2021, Blue Shield Promise would increase the percentage of well-child visits among Family Health Centers of San Diego members from 64 percent to the NCQA Medicaid national 50th percentile rate of 74 percent. During the development of the process map and key driver diagram, Blue Shield Promise identified potential interventions based on barriers identified by Family Health Centers of San Diego and Blue Shield Promise. Those barriers included incorrect member contact information and access to care, including the need for extended clinic hours in the evening and weekends or in-home services, or the need to incentivize members to show up for

2018–19 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	scheduled appointments. Due to COVID-19, it was determined by Family Health Centers of San Diego and Blue Shield Promise to implement an in-person gift card incentive program for members to improve the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate. Family Health Centers of San Diego continued to see members for in-person visits but struggled to get members to show up for appointments. In April and May 2020, Blue Shield Promise received DHCS' approval to implement the gift card incentive program for members and developed an intervention plan based on the identified failure mode and key driver. Blue Shield Promise had received approval from HSAG to continue with the planned intervention; however, due to COVID-19, future 2019–21 PIP submissions were canceled. Despite the PIP ending, Blue Shield Promise has determined to move forward with the in-person gift card member incentive for completion of well-child visits for members ages 3 to 6 years. The program is launching in July 2020. The impact of the program on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure will be monitored. If the program is determined to be successful, it will be expanded to other measures and clinics. In addition to this targeted member incentive program that is a part of our PIP intervention, Blue Shield Promise also has the Healthy Rewards Program for all other children ages 3 to 6 years of age. This program mails members incentive information which they can redeem upon completion of a well-child visit.

2018–19 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	Blue Shield Promise also conducted outreach to all members who were identified as needing a well-child visit in 2019, and the outreach has continued into 2020. While our outreach efforts have been impacted due to COVID-19, we are still continuing to outreach to members to educate them on the importance of well-child visits and immunizations.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Blue Shield Promise's self-reported actions in Table 8.1 and determined that Blue Shield Promise adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. Blue Shield Promise described in detail interventions the MCP conducted to improve its performance on the *Asthma Medication Ratio—Total* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures to above the minimum performance levels. Interventions included member outreach, incentives, and education.

2019–20 Recommendations

Based on the overall assessment of Blue Shield Promise's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- ♦ Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs.
- ♦ Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.

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

Medi-Cal Managed Care External Quality Review Technical Report

Appendix G: Performance Evaluation Report California Health & Wellness Plan July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, California Health & Wellness Plan ("CHW" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in CHW's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CHW is a full-scope MCP delivering services to its members under the Regional and Imperial models. In all counties, beneficiaries may enroll in CHW or the other commercial plan.

CHW became operational to provide MCMC services effective November 1, 2013. Table 1.1 shows the counties in which CHW provides MCMC services, the other commercial plans for each county, CHW's enrollment for each county, the MCP's total number of members, and the percentage of beneficiaries in the county who were enrolled in CHW as of June 2020.[1]

Table 1.1—CHW Enrollment as of June 2020

County	Other Commercial Plan	CHW Enrollment as of June 2020	Percentage of Beneficiaries in the County Enrolled in CHW
Alpine	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan (Anthem Blue Cross)	71	33%
Amador	Anthem Blue Cross Kaiser NorCal	1,229	20%
Butte	Anthem Blue Cross	39,449	64%
Calaveras	Anthem Blue Cross	5,000	53%
Colusa	Anthem Blue Cross	3,344	42%
El Dorado	Anthem Blue Cross Kaiser NorCal	17,525	61%
Glenn	Anthem Blue Cross	7,609	75%
Imperial	Molina Healthcare of California Partner Plan, Inc.	62,228	81%
Inyo	Anthem Blue Cross	1,837	46%

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

County	Other Commercial Plan	CHW Enrollment as of June 2020	Percentage of Beneficiaries in the County Enrolled in CHW
Mariposa	Anthem Blue Cross	830	20%
Mono	Anthem Blue Cross	885	36%
Nevada	Anthem Blue Cross	8,362	43%
Placer	Anthem Blue Cross Kaiser NorCal	9,507	21%
Plumas	Anthem Blue Cross	2,568	49%
Sierra	Anthem Blue Cross	230	40%
Sutter	Anthem Blue Cross	10,852	34%
Tehama	Anthem Blue Cross	12,211	58%
Tuolumne	Anthem Blue Cross	4,999	49%
Yuba	Anthem Blue Cross	9,516	37%
Total		198,252	

Under the Regional model, DHCS allows CHW to combine data from multiple counties to make up two single reporting units—Region 1 and Region 2. The counties within each of these reporting units are as follows:

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

The Imperial model consists of one reporting unit with a single county, Imperial County.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CHW.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CHW. A&I conducted the audits from February 24, 2020, through March 3, 2020. During the audits, A&I examined CHW's compliance with its DHCS contract and assessed implementation of the MCP's prior year corrective action plan (CAP), which DHCS closed on January 15, 2020. DHCS issued the final closeout letter on November 20, 2020, which is outside the review period for this report; however, HSAG includes the information from the letter because it reflects full resolution of the findings from the audits.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CHW
Audit Review Period: December 1, 2018, through November 30, 2019

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

Follow-Up on 2019 A&I Medical Audit of CHW

A&I conducted a Medical Audit of CHW in February 2019, covering the review period of December 1, 2017, through November 30, 2018. HSAG provided a summary of the audit results and status in CHW's 2018–19 MCP-specific evaluation report. At the time of the 2018–19 MCP-specific evaluation report publication, CHW's CAP was in progress and under review by DHCS. A letter from DHCS dated January 15, 2020, stated that CHW provided DHCS with additional information regarding the CAP, and that DHCS had reviewed the information and closed the CAP. The letter indicated that DHCS would monitor the MCP's full implementation of the CAP during the subsequent audit.

Strengths—Compliance Reviews

In response to the CAP from the 2019 A&I Medical Audit, CHW submitted documentation to DHCS regarding the MCP's processes for the following:

- Monitoring the completion of a member's initial health assessment (IHA) within the required time frame.
- Family planning prior authorizations.
- Grievance resolutions.
- IHA quality improvement.
- Transportation quality improvement.

CHW's responses to the MCP's CAP resulted in DHCS closing the 2019 A&I Medical Audit CAP.

During the 2020 A&I Medical and State Supported Services Audits of CHW, A&I identified a finding in only one category (Case Management and Coordination of Care). In response to the CAP, CHW indicated that it updated its policies and procedures to ensure the MCP is in full compliance with the Physician Certification Statement requirements. CHW's response resulted in DHCS closing the 2020 A&I Medical Audit CAP.

Opportunities for Improvement—Compliance Reviews

CHW has no outstanding findings from the 2019 or 2020 A&I Medical Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures CHW chose to report using one or both of these two options.

[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- ♦ Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- ♦ Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of CHW, and the *HEDIS 2020 Compliance Audit Final Report of Findings for California Health & Wellness Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that CHW followed the appropriate specifications to produce valid rates; however, during primary source verification of a sample of randomly selected dual eligibility exclusions, the auditor noted that several members only had dual eligible coverage during part of the measurement year. The auditor indicated that to comply with NCQA's General Guideline 15 in which exclusions are to be applied according to the continuous enrollment requirements for each measure, CHW should implement dual eligibility calculations in monthly enrollment spans.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.10 for CHW's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.10:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 through Table 3.3 present the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CHW—Imperial County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	48.18%
Childhood Immunization Status—Combination 10	30.41%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	96.96%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	89.24%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	87.39%

Measure	Reporting Year 2020 Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	83.97%
Developmental Screening in the First Three Years of Life—Total	25.02%
Immunizations for Adolescents—Combination 2	37.23%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	88.32%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	56.93%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.70%

Table 3.2—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	48.18%
Childhood Immunization Status—Combination 10	29.93%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	94.34%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	87.67%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	88.15%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	86.25%
Developmental Screening in the First Three Years of Life—Total	30.14%
Immunizations for Adolescents—Combination 2	30.66%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	70.80%

Measure	Reporting Year 2020 Rate
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	46.72%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.74%

Table 3.3—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	46.23%
Childhood Immunization Status—Combination 10	24.33%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	90.70%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	81.58%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	81.66%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	81.08%
Developmental Screening in the First Three Years of Life—Total	17.96%
Immunizations for Adolescents—Combination 2	28.71%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	75.67%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	58.15%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.57%

Assessment of Corrective Action Plan—Children's Health Domain

In April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that CHW conducted as part of its CAP prior to April 2020.

Following DHCS' assessment of CHW's reporting year 2018 performance measure results, DHCS placed CHW under an MCP-wide CAP. Based on reporting year 2019 performance measure results, the following measures within the Children's Health domain were included in CHW's CAP:

- *Childhood Immunization Status—Combination 3* in regions 1 and 2
  - Note that DHCS required MCPs to report rates for the *Childhood Immunization Status—Combination 10* measure in reporting year 2020 in place of the *Childhood Immunization Status—Combination 3* measure; therefore, CHW's CAP quality improvement activities focused on the *Childhood Immunization Status—Combination 10* measure.
- *Immunizations for Adolescents—Combination 2* in Region 1
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in regions 1 and 2

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of CHW's performance related to measures within the Children's Health domain for which the MCP conducted PDSA cycles or a PIP.

Childhood and Adolescent Immunizations

DHCS approved CHW to conduct one set of PDSA cycles to address the MCP's performance below the minimum performance levels for the *Childhood Immunization Status—Combination 10* measure in regions 1 and 2 and the *Immunizations for Adolescents—Combination 2* measure in Region 1. CHW planned to conduct telephonic outreach to parents/caregivers of members who were not compliant with receiving all required immunizations for both the *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* measures to remind them of their child's/adolescent's missed appointment. Additionally, CHW planned to conduct the outreach using a three-way calling approach to allow for scheduling the immunization appointments during the calls. CHW planned to target households in Region 1 with more than one member eligible for an immunization visit to increase the potential of improving the measure rates. Due to multiple providers discontinuing their participation in this intervention and the need to prioritize efforts to respond to COVID-19, the MCP placed the intervention on hold.

Well-Child Visits

DHCS approved for CHW to conduct a PIP to address the rates for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure being below the minimum performance level in regions 1 and 2 in reporting year 2019. Because DHCS approved the MCP to conduct a PIP, DHCS did not require the MCP to conduct additional quality improvement activities related to this measure. HSAG includes a summary of CHW's progress on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP in Section 4 of this report ("Performance Improvement Projects").

Women's Health Domain

Results—Women's Health Domain

Table 3.4 through Table 3.6 present the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.4—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CHW—Imperial County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	65.84%
Cervical Cancer Screening	69.83%
Chlamydia Screening in Women—Ages 16–20 Years	44.13%
Chlamydia Screening in Women—Ages 21–24 Years	67.90%
Chlamydia Screening in Women—Total	55.76%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.84%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	28.17%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.51%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.63%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	12.80%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	37.88%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.51%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	5.68%
Prenatal and Postpartum Care—Postpartum Care	76.16%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.97%

Table 3.5—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	53.51%
Cervical Cancer Screening	52.57%
Chlamydia Screening in Women—Ages 16–20 Years	49.59%
Chlamydia Screening in Women—Ages 21–24 Years	60.07%
Chlamydia Screening in Women—Total	54.78%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	25.09%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	28.00%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.30%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.38%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	10.85%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	56.52%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.38%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	19.57%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.35%
Prenatal and Postpartum Care—Postpartum Care	79.32%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.24%

Table 3.6—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	50.34%
Cervical Cancer Screening	61.07%
Chlamydia Screening in Women—Ages 16–20 Years	38.40%
Chlamydia Screening in Women—Ages 21–24 Years	57.89%
Chlamydia Screening in Women—Total	46.79%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	28.90%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.10%

Measure	Reporting Year 2020 Rate
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.36%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.63%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.42%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	42.86%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	40.65%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	11.81%
Prenatal and Postpartum Care—Postpartum Care	78.35%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.75%

Assessment of Corrective Action Plan—Women's Health Domain

As previously stated, in April 2020, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that CHW conducted as part of its CAP prior to April 2020.

Based on reporting year 2019 performance measure results, the *Breast Cancer Screening—Total* measure was included in CHW's CAP. DHCS approved CHW to conduct PDSA cycles to address the MCP's performance below the minimum performance level for this measure in regions 1 and 2.

CHW tested whether holding mobile mammography events in a central location for members who were due for mammograms and had been assigned to one of three selected provider partners in Region 2 would improve the MCP's performance for the *Breast Cancer Screening—Total* measure. CHW noted that while it was unable to contact 45 percent of

targeted members due to having incorrect or incomplete contact information or encountering busy signals or non-working numbers, members who were contacted and had attended a breast cancer screening appointment were motivated to complete a mammogram because CHW offered an incentive to do so. Additionally, the CHW provider relations and health educator staff members reported that members reached by phone were receptive to the health education provided and the appointment scheduling assistance.

DHCS did not hold MCPs accountable to meet the minimum performance level for the *Breast Cancer Screening—Total* measure in reporting year 2020; therefore, HSAG makes no assessment of CHW's performance related to this measure.

Behavioral Health Domain

Table 3.7 through Table 3.9 present the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.7—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CHW—Imperial County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	53.49%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	36.14%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	28.33%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	S
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	2.50%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.57%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%

Table 3.8—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	52.21%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	35.31%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	54.73%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	66.00%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.32%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%

Table 3.9—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	57.54%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	44.02%

Measure	Reporting Year 2020 Rate
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	39.86%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	48.48%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.06%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.10 through Table 3.12 present the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.10—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
CHW—Imperial County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	93.19%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	51.26
Asthma Medication Ratio—Total	69.17%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	32.84%
Comprehensive Diabetes Care—HbA1c Testing—Total	89.88%

Measure	Reporting Year 2020 Rate
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	7.66%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	73.24%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.04%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.21%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.98
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	2.30%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.11—Acute and Chronic Disease Management Domain Reporting Year 2020 Performance Measure Results CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.97%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	48.12
Asthma Medication Ratio—Total	60.94%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	37.32%

Measure	Reporting Year 2020 Rate
Comprehensive Diabetes Care—HbA1c Testing—Total	86.10%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	12.79%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	62.04%
HIV Viral Load Suppression—Ages 18–64 Years	S
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.62%
Plan All-Cause Readmissions—Expected Readmissions—Total	10.28%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.84
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.35%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.12—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.00%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	54.70
Asthma Medication Ratio—Total	58.42%

Measure	Reporting Year 2020 Rate
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	36.98%
Comprehensive Diabetes Care—HbA1c Testing—Total	84.43%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.67%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	61.56%
HIV Viral Load Suppression—Ages 18–64 Years	S
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.30%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.84%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.94
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	8.55%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Assessment of Corrective Action Plan—Acute and Chronic Disease Management Domain

As previously stated, in April 2020, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that CHW conducted as part of its CAP prior to April 2020.

Based on reporting year 2019 performance measure results in Region 2, the following two measures within the Acute and Chronic Disease Management domain were included in CHW's CAP:

- *Asthma Medication Ratio—Total*
- *Comprehensive Diabetes Care—HbA1c Testing—Total*

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of CHW's performance related to measures within the Acute and Chronic Disease Management domain for which the MCP conducted PDSA cycles.

Asthma Medication Ratio—Total

DHCS approved CHW to conduct PDSA cycles to address the MCP's performance below the minimum performance level for the *Asthma Medication Ratio—Total* measure in Region 2.

CHW planned to conduct a text messaging campaign to address members' lack of knowledge about the importance of asthma controller medications. Through texting, the MCP intended to ask members if they had enough asthma controller medications for the next 30 days and, if needed, refer members to CHW's member services department for assistance with refilling their prescriptions or contacting their providers to obtain new prescriptions. Due to delays in receiving approval from DHCS to use the identified vendor and text messages, and the need to prioritize efforts to respond to COVID-19, the MCP placed the intervention on hold.

Comprehensive Diabetes Care—HbA1c Testing—Total

DHCS approved CHW to conduct PDSA cycles to address the MCP's performance below the minimum performance level for the *Comprehensive Diabetes Care—HbA1c Testing—Total* measure in Region 2.

CHW tested whether having a clinic partner's staff members use a provider profile to monitor outreach efforts and schedule targeted members to complete HbA1c testing would result in the *Comprehensive Diabetes Care—HbA1c Testing—Total* measure rate improving. CHW reported that it found members were receptive to the education and to completing HbA1c testing. The MCP indicated that it planned to continue conducting ongoing education and refresher courses for staff members.

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, CHW will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Note that in September 2020, DHCS notified CHW that DHCS was closing the MCP's CAP, which was based on DHCS' previous performance measure set (External Accountability Set). To ensure continued monitoring of CHW's performance, DHCS will require CHW to meet quarterly via telephone with the MCP's assigned DHCS nurse consultant. While DHCS notified CHW of the CAP closure outside the review period for the MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.13 through Table 3.15 present the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.13—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CHW—Imperial County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	96.12	49.13	Not Tested	51.26

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	NA	96.93%	Not Comparable	96.96%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	93.67%	89.13%	4.54	89.24%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	92.80%	87.17%	5.63	87.39%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	89.17%	83.83%	5.34	83.97%
*Plan All-Cause Readmissions— Total***	11.11%	8.44%	2.67	9.04%

Table 3.14—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CHW—Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties)

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	80.58	45.02	Not Tested	48.12
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	NA	94.31%	Not Comparable	94.34%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	88.59%	87.65%	0.94	87.67%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	94.91%	87.93%	6.98	88.15%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	86.60%	86.24%	0.36	86.25%
*Plan All-Cause Readmissions— Total***	10.13%	7.67%	2.46	8.62%

Table 3.15—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CHW—Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties)

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	94.76	51.58	Not Tested	54.70
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	90.65%	Not Comparable	90.70%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	85.92%	81.52%	4.40	81.58%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	75.41%	81.83%	-6.42	81.66%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	78.92%	81.14%	-2.22	81.08%
*Plan All-Cause Readmissions—Total***	12.32%	7.97%	4.35	9.30%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures for which HSAG could make a comparison between the reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results for measures that CHW stratified by the SPD and non-SPD populations:

- The reporting year 2020 SPD rates were significantly better than the reporting year 2020 non-SPD rates for the following measures:
  - *Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years* in Imperial County and Region 1
  - *Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years* in Imperial County

- In reporting year 2020, the SPD population had a significantly higher hospital readmissions rate than the non-SPD population in regions 1 and 2. Note that the higher rates of hospital readmissions for the SPD population are expected based on the greater and often more complicated health care needs of these beneficiaries.

Strengths—Performance Measures

The HSAG auditor determined that CHW followed the appropriate specifications to produce valid rates.

Opportunities for Improvement—Performance Measures

CHW has the opportunity to update the MCP's enrollment determinations to monthly spans and implement dual eligibility calculations to ensure that dual eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, CHW submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, CHW initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

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

Table 4.1 provides the SMART Aim measure results reported by the MCP for its *Controlling High Blood Pressure* Disparity PIP.

Table 4.1—CHW *Controlling High Blood Pressure* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of controlled blood pressure among Hispanic members diagnosed with hypertension at Health Center A located in Region 2[6]	69.8%	91.0%	Not Determined

[6] Health center name removed for confidentiality.

Table 4.2 presents a description of the intervention that CHW tested for its *Controlling High Blood Pressure* Disparity PIP. The table also indicates the key drivers and failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—CHW *Controlling High Blood Pressure* Disparity PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide health center partner with trackable reports that identify members who are non-compliant for the *Controlling High Blood Pressure* measure	♦ Members have a difficult time accessing appointments due to long wait times which can impact their work schedules ♦ Members are overwhelmed by the initial hypertension diagnosis ♦ Members do not keep appointments	Adopt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CHW's *Controlling High Blood Pressure* Disparity PIP. In the modules that it tested, CHW documented providing its health center partner monthly reports that identify members who are non-compliant for the *Controlling High Blood Pressure* measure. The MCP made the reports in a trackable format to facilitate data collection. The health center partner outreached to members to schedule their appointments and used the reports to track whether the members attended the scheduled appointment. CHW indicated testing the intervention from April 2019 through June 2019.The MCP reported that the health center partner outreached to 187 members who were non-compliant for the *Controlling High Blood Pressure* measure and that 114 of those members attended their scheduled appointments. The MCP decided to adopt the intervention. Based on PIP documentation, HSAG was unable to determine whether the MCP met the SMART Aim goal because the intervention and the SMART Aim measure data did not reflect a focus on the disparate Hispanic members.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CHW's *Controlling High Blood Pressure* Disparity PIP a final confidence level of *Not Credible*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on CHW's reporting year 2017 performance measure results, the MCP selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure results as reported by the MCP for its *Childhood Immunization Status—Combination 3* PIP.

Table 4.3—CHW *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate for *Childhood Immunization Status—Combination 3* measure for Clinic A[7]	42.71%	58.00%	No

Table 4.4 presents a description of the intervention that CHW tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.4—CHW *Childhood Immunization Status—Combination 3* PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide $50 gift card incentive to eligible members at Clinic A for timely completion of the immunization series	♦ Member engagement ♦ Parents do not prioritize the recommended timing for members' vaccinations	Abandon

[7] Clinic name removed for confidentiality.

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CHW's *Childhood Immunization Status—Combination 3* PIP. CHW documented in the modules that it tested offering an incentive to members for completing their immunization series. The MCP completed two outreach cycles in April 2019 and May 2019; however, none of the outreached members were able to complete the immunization series by the end of this PIP, and CHW decided to abandon the intervention. Prior to testing the member incentive intervention, CHW planned to test implementing a monthly immunization clinic. The MCP began its efforts in July 2018 but was unable to hold the immunization clinic for several months due to not having enough members sign up for the clinic. With numerous delays in initiating the intervention as well as the provider partner site's resource shortages, CHW was unable to test the immunization clinic intervention. Despite CHW's efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CHW's *Childhood Immunization Status—Combination 3* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, CHW identified cervical cancer screening in Region 2 as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Cervical Cancer Screening* Health Equity PIP. Upon initial review of the modules, HSAG determined that CHW met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.
- Including all required components of the SMART Aim run chart.
- Labeling clearly the identified gaps or opportunities for improvement in the process map steps.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Linking logically the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.

After receiving technical assistance from HSAG, CHW incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. CHW was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, CHW selected well-child visits among members ages 3 to 6 years as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. Upon initial review of the modules, HSAG determined that CHW met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.
- Including all required components of the SMART Aim run chart.
- Linking logically the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.
- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.
- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.

After receiving technical assistance from HSAG, CHW incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. CHW was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, CHW identified an intervention that it can adopt to improve blood pressure control among its members living with hypertension.

Opportunities for Improvement—Performance Improvement Projects

CHW has the opportunity to monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Controlling High Blood Pressure* Disparity PIP. The MCP should apply lessons learned from the 2017–19 PIPs to strengthen future quality improvement efforts.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

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

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

HSAG also evaluated the following:

- ♦ The extent to which providers are aware of interpretation service requirements.
- ♦ The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

CHW submitted its PNA report to DHCS on June 30, 2020, and DHCS notified the MCP via email on July 16, 2020, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 7.1 provides EQR recommendations from CHW's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of CHW's self-reported actions.

Table 7.1—CHW's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP fully resolves all findings from the 2019 A&I Medical and State Supported Services Audits.	CHW worked with DHCS to resolve the 2019 Medical and State Supported Services audit findings. A CAP addressing the findings was submitted on July 22, 2019, and the audit was closed on January 15, 2020.
2. For the following six measures with rates below the minimum performance levels in reporting year 2019, assess whether the MCP's current improvement strategies need to be modified or expanded to improve the MCP's performance to above the minimum performance levels:	
♦ *Asthma Medication Ratio* in Region 2 (The rate for this measure was also below the minimum performance level in reporting year 2018 for Region 2.)	***Asthma Medication Ratio*** ♦ In Q3 and Q4 of 2019, and Q1 and Q2 of 2020, a texting outreach program was developed and conducted in CHW Region 2. This outreach targeted members who are non-adherent with their asthma controller medication refills based on the HEDIS *Asthma Medication Ratio* measure specification. The text message lessons included education on the different types of asthma medications (controller and rescue medications), reinforcement of the importance of medication adherence, and encouragement to fill their asthma medication prescriptions. The pilots for these campaigns concluded March 20, 2020. Pharmacy

2018–19 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	outreach calls and text messages will be going out to members with asthma in the asthma Health Benefits Ratio. All members with asthma in CHW regions 1 and 2 who are in the *Asthma Medication Ratio* measure denominator will receive these messages. The campaign is set to launch in Quarter 3 of 2020. Member lists have already been pulled for these efforts.
♦ *Breast Cancer Screening* in regions 1 and 2 (The rates for this measure were also below the minimum performance level in reporting year 2018 for regions 1 and 2.)	***Breast Cancer Screening*** ♦ In Q3 and Q4 of 2019, the Provider Engagement Team reviewed care gap reports with high-volume, low-performing providers. ♦ CHW completed a joint mobile mammography event that took place in a centralized location on November 19, 2019. This was in partnership with three CHW Region 2 clinics. The Provider Engagement Department provided outreach to eligible members with breast cancer screening care gaps. Out of the members called, 10.45 percent completed their breast cancer screening and received a member incentive. ♦ The first CHW Region 2 *Breast Cancer Screening* measure PDSA report was submitted in mid-October 2019. Members received a $25 point-of-care incentive for attending mobile mammography events in CHW regions 1 and 2. Members with a history of care in 2018 were prioritized and provided scheduling assistance if needed. In addition, the HEDIS team completed calls to non-compliant members and informed them about the point-of-care incentive being offered during events and direct interventions such as one-stop clinics. Members were also eligible for an incentive for care received through a scheduled visit with a doctor for a mammogram. The mobile mammography program held events for members across all CHW regions. Six events were held in Q3 2019, resulting in 100 members being screened. Three events were held in Q4 2019, resulting in 50 members screened. CHW mapped breast cancer screening non-

2018–19 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	compliant members in relation to contracted radiology centers to better serve those within a five, 10, 20, and 20+ mile radius. This information was used to improve targeted approaches to members by: ■ Partnering with radiology centers/providers to get members scheduled at a nearby radiology site. ■ Holding mobile mammography events in areas where radiology sites are scarce. ■ Offering incentives to non-compliant members in targeted regions for completing recommended screenings and closing gaps in care. ♦ In Q1 and Q2 of 2020, mobile mammography events continued to be coordinated between CHW and its clinic partners. Incentives continued on-site for those who completed a screening. In Q1 2020, one event was held, resulting in 13 members screened. As part of our rural planning for CHW Region 2, the MCP engaged providers to participate in multiple mobile mammography events for their patients at a central location to meet members' needs. By including more than one clinic, the intervention was able to target additional members for the event and eliminate time and transportation barriers by setting up a mobile mammography coach in a central location. ♦ CHW planned to pilot a new strategy for mobile mammography events to our target population of 150 breast cancer screening non-compliant members across three partner clinics. Initial planning for PDSA Cycle 3 occurred in Q1 2020 with plans to modify the intervention by identifying potential provider clinics and top-reporting CHW radiology/imaging sites for referral and completion of a breast cancer screening. The *Breast Cancer Screening* measure PDSA cycle was cancelled subsequent to DHCS lifting the PDSA cycle requirements for MCPs during Q2 2020 due to COVID-19 restrictions.

2018–19 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ CHW distributed rewards to members who had services completed in 2019 through Q2 of 2020. This program ended June 30, 2020. The planned launch for the 2020 Medi-Cal Member Reward Cards is Q3 2020, pending DHCS approval for this program.
♦ *Childhood Immunization Status—Combination 3* in regions 1 and 2 (The rates for this measure have been below the minimum performance levels for more than three consecutive years in Region 2.)	***Childhood Immunization Status—Combination 3*** ♦ In Q3 and Q4 of 2019, CHW offered incentives to non-compliant members in targeted regions for completing recommended screenings and closing gaps in care. In addition, the HEDIS team completed calls to parents of members turning 2 years old to remind them about needed vaccinations and schedule the members for needed vaccination appointments. The point-of-care incentive was offered during events and direct interventions such as one-stop clinics. Members received a $50 point-of-care incentive for completing the entire *Childhood Immunization Status—Combination 10* series. This intervention was conducted in all CHW regions. ♦ In Q1 and Q2 of 2020, the monthly *Childhood Immunization Status* flu series outreach was completed to parents of members 6 to 23 months old who had not completed the *Childhood Immunization Status* flu series. ♦ The HEDIS team performed live calls to non-compliant members to offer a member incentive for completing a service and provide scheduling assistance. Live call outreach was finalized January 20, 2020, for all non-compliant members from all CHW regions who were turning 2 years old in the next two months. The Health Education Department conducted phone education and appointment scheduling to help non-compliant members understand the importance of preventive health services (immunizations, diabetes screenings, well-child visits, and breast and cervical cancer screenings) and schedule them to attend a one-

2018–19 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	stop, point-of-care, or community health-screening event. ♦ CHW worked with a high-volume, low-performing Region 1 provider to implement point-of-care incentives for *Childhood Immunization Status* completion. The point-of-care incentives helped to encourage parents to follow through with scheduling appointments for their children to receive needed vaccinations. However, by Q1 2020, the targeted provider reported that it was unable to participate in the PDSA cycle due to multiple barriers, including staffing challenges and other competing provider priorities. During Q1 2020, a new MCP strategy and interventions were identified involving the CHW Member Connections Team to offer scheduling assistance for members missing *Childhood Immunization Status—Combination 10* immunizations. The MCP identified two high-volume, low-performing clinics with which to partner. This team used a "household" approach which consisted of only contacting parents and caregivers with more than one member in the home eligible for a *Childhood Immunization Status—Combination 10* visit. By Q2 2020, DHCS had lifted the PDSA cycle requirements for MCPs due to COVID-19 restrictions. ♦ CHW distributed rewards to members who had services completed in 2019 through Q2 of 2020. This program ended June 30, 2020. The planned launch for the 2020 Medi-Cal Member Reward Cards is Q3 2020, pending DHCS approval for this program.
♦ *Comprehensive Diabetes Care—HbA1c Testing* in Region 2	***Comprehensive Diabetes Care—HbA1c Testing*** ♦ In Q3 and Q4 of 2019, the in-home health assessment program, MedXM, completed outreach in all CHW counties to all non-compliant *Comprehensive Diabetes Care* members in measurement year 2019. The data were prioritized to identify 80 percent or more of our members who reside in high-volume ZIP Codes to maximize

2018–19 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	outreach efforts. CHW collaborated with a high-volume, low-performing clinic to improve the *Comprehensive Diabetes Care—HbA1c Testing* measure rate. The identified interventions included phone outreach provided by the clinic, assistance with scheduling member appointments, and standing orders for labs. Results included: ■ 31.08 percent of the members completed their HbA1c testing. ■ 13.51 percent of the members scheduled appointments. ■ Voice messages were left for 16.22 percent of the members. ■ 39.19 percent of the members did not show up for their HbA1c testing appointment. ♦ In Q1 2020, initial planning for PDSA Cycle 3 occurred with plans to move forward collaborating with the same provider with an adapted intervention, including additional text messaging outreach. ♦ CHW continues to offer incentives to non-compliant members in targeted regions for completing recommended screenings and closing gaps in care. The point-of-care incentive was offered during events and direct interventions such as one-stop clinics. Members received a $50 point-of-care incentive for completion of services related to all three *Comprehensive Diabetes Care* sub-measures: *Eye Exam (Retinal) Performed*, *Medical Attention for Nephropathy*, and *HbA1c Testing*. Outreach targeted CHW regions 1 and 2, prioritizing members with a history of receiving care in 2018, offering scheduling assistance. ♦ The HEDIS team performed live calls to non-compliant members to offer a member incentive for completing a service and provide scheduling assistance. The Health Education Department conducted phone education and appointment scheduling to help non-compliant members understand the importance of preventive health services (immunizations, diabetes screenings, well-

2018–19 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	child visits, and breast and cervical cancer screenings) and schedule the members to attend a one-stop, point-of-care, or community health-screening event. ♦ Providers engaged in point-of-care testing, supplemented with a member incentive for *Comprehensive Diabetes Care*. In Q1 2020, there was a launch of U.S. Medical Management, LLC (USMM) home mailing kits for HbA1c testing in regions 1 and 2. ♦ The CHW Region 2 *Comprehensive Diabetes Care—HbA1c Testing* measure PDSA cycle included collaboration with a high-volume clinic to increase outreach and scheduling activities to eligible members. The clinic also executed standing orders to improve screening rates. In Q2 2020, DHCS lifted PDSA cycle requirements for MCPs due to COVID-19 restrictions, so CHW elected to end the *Comprehensive Diabetes Care—HbA1c Testing* PDSA cycle.
♦ *Immunizations for Adolescents—Combination 2* in Region 1	***Immunizations for Adolescents—Combination 2*** ♦ In Q3 2019 and Q4 2019, CHW continued to offer incentives to non-compliant members in targeted regions for completing recommended screenings and closing gaps in care. The HEDIS team performed live calls to non-compliant members to offer a member incentive for completing a service and provide scheduling assistance. ♦ CHW offered a point-of-care incentive during clinic events and direct interventions (e.g., one-stop clinics). CHW incentivized gap closures and added a $25 incentive for member completion of services related to the *Immunizations for Adolescents* measure. ♦ In Q1 and Q2 of 2020, CHW continued to offer incentives to non-compliant members for closing gaps in care. This is a multichannel outreach effort to non-compliant members to reward completion of individually defined health care activities. The planned deployment was Q1 2020 but was

2018–19 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	postponed due to delays in the approval process with DHCS. The following are interventions included in this effort: ■ The HEDIS team performed calls to non-compliant members to offer a member incentive for completing a service and provide scheduling assistance. This outreach plan was finalized on January 20, 2020. ■ Point-of-Care Incentive: In early February 2020, the MCP supported a scheduled event with incentive distribution. This took place in cooperation with the Marshall Clinic in CHW Region 2. ■ The Health Education Department: ○ Focused on social media, offering expanded social media messaging options, including daily themes and new public service announcements. ○ Distributed information and materials through multiple avenues such as Facebook, Twitter, and other social media sites to raise awareness about human papillomavirus (HPV), Tdap, meningococcal, and varicella vaccines for boys and girls, as well as to promote the preteen doctor visit. ○ Conducted phone education and appointment scheduling to help non-compliant members understand the importance of preventive health services (immunizations, diabetes screenings, well-child visits, and breast and cervical cancer screenings) and schedule them to attend a one-stop, point-of-care, or community health-screening event. ○ Participated in a statewide event called “Preteen Vaccination Week” jointly led by the California Department of Public Health (CDPH) and the Centers for Disease Control and Prevention in March 2020. During this event, CDPH promoted various health

2018–19 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	education materials related to immunizations and developed a week-long social media post-campaign geared toward driving parents and adolescents toward obtaining proper vaccinations. This event had a total reach of 3,322 members. ♦ CHW collaborated with a high-volume, low-performing CHW Region 1 provider to implement point-of-care incentives for *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* immunization series completion. The point-of-care incentives were used during outreach to help motivate parents to schedule their children for needed vaccinations. However, by Q1 2020 the targeted provider reported that it was unable to participate in the PDSA cycles due to multiple barriers, including staffing challenges and other competing provider priorities. During Q1 2020, CHW identified a new strategy and interventions involving the CHW Member Connections Team and call representatives to offer scheduling for members missing *Immunizations for Adolescents—Combination 2* visits and identified two high-volume, low-performing clinics. The CHW Member Connections Team used a "household" approach which consisted of contacting parents and caregivers with more than one member in the home eligible for a *Childhood Immunization Status—Combination 10* or *Immunizations for Adolescents—Combination 2* visit. By Q2 2020, DHCS lifted PDSA cycle requirements for MCPs due to COVID-19 restrictions, so CHW elected to end the *Immunizations for Adolescents—Combination 2* PDSA cycle.
♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in regions 1 and 2 (The rates for this measure have been below the minimum performance levels for more	***Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*** ♦ In Q3 and Q4 of 2019, a PDSA cycle was completed with a high-volume clinic, Ampla Health, for weekend pediatric clinics focused on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth*

2018–19 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
than three consecutive years in Region 2.)	*Years of Life* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total* HEDIS measures. ♦ CHW continued to offer incentives to non-compliant members in targeted regions for completing recommended screenings and closing gaps in care: ■ The HEDIS team performed live calls to non-compliant members. ■ CHW offered a point-of-care incentive during clinic events and direct interventions (e.g., one-stop clinics) ■ CHW offered a $25 incentive related to the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, targeting all CHW regions. ♦ CHW submitted Module 1 for the CHW Region 2 *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP in November 2019 and Module 2 in March 2020. The MCP was collaborating with Marshall Medical Foundation for the PIP to identify and implement initiatives to improve *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates for their membership. Due to COVID-19 restrictions, DHCS chose to end the PIPs early in June 2020. ♦ The Health Education Department conducted phone education and appointment scheduling to help non-compliant members understand the importance of preventive health services (immunizations, diabetes screenings, well-child visits, and breast and cervical cancer screenings) and schedule them to attend a one-stop, point-of-care, or community health-screening event. ♦ The HEDIS team performed live calls to non-compliant members to offer a member incentive for completing a service and provided scheduling assistance. Live call outreach was finalized January 20, 2020, for calls to members in regions 1 and 2.

2018–19 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ To strengthen our relationship, we are embarking on Joint Operations meetings between Provider Engagement/Practice Transformation consultants and high-volume providers. ♦ CHW distributed rewards to members who had services completed in 2019 through Q2 of 2020. This program ended June 30, 2020. The planned launch for the 2020 Medi-Cal Member Reward Cards is Q3 2020, pending DHCS approval for this program.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CHW's self-reported actions in Table 7.1 and determined that CHW adequately addressed HSAG's recommendations from the July 1, 2018, through June 30, 2019, MCP-specific evaluation report. CHW described in detail the actions the MCP took to improve its performance, including implementing targeted interventions and expanding partnerships. CHW also described outcomes and next steps related to quality improvement efforts. While COVID-19 resulted in most of CHW's efforts being halted, the MCP's self-reported actions reflect that it continues to move forward on as many quality improvement activities as possible within the constraints of the pandemic.

2019–20 Recommendations

Based on the overall assessment of CHW's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- ♦ Update the MCP's enrollment determinations to monthly spans and implement dual eligibility calculations to ensure that dual eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.
- ♦ Monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Controlling High Blood Pressure* Disparity PIP.
- ♦ Apply lessons learned from the 2017–19 PIPs to strengthen future quality improvement efforts.

In the next annual review, the EQRO will evaluate continued successes of CHW as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix H:
Performance Evaluation Report
CalOptima
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, CalOptima (or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in CalOptima's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CalOptima is a full-scope MCP delivering services to its members in the County Organized Health System model.

CalOptima became operational to provide MCMC services in Orange County effective October 1995. As of June 2020, CalOptima had 739,736 members in Orange County.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CalOptima.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CalOptima. A&I conducted the audits from January 27, 2020, through February 7, 2020. DHCS issued the final reports on August 11, 2020, which is outside the review period for this report; however, HSAG includes the information from the reports because A&I conducted the on-site audits during the review period for this report.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CalOptima Audit Review Period: February 1, 2019, through January 31, 2020

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

Follow-Up on 2019 A&I Medical Audit of CalOptima

A&I conducted a Medical Audit of CalOptima in February 2019, covering the review period of February 1, 2018, through January 31, 2019. HSAG provided a summary of the audit results and status in CalOptima's 2018–19 MCP-specific evaluation report. At the time of the 2018–19 MCP-specific evaluation report publication, CalOptima's CAP was in progress and under review by DHCS. A letter from DHCS dated March 20, 2020, stated that CalOptima provided

DHCS with additional information regarding the CAP, and that DHCS had reviewed the information and closed the CAP. The letter indicated that DHCS would monitor the MCP's full implementation of the CAP during the subsequent audit.

Strengths—Compliance Reviews

In response to the CAP from the February 2019 A&I Medical Audit, CalOptima submitted documentation to DHCS regarding the MCP's policies and procedures for the following:

- ♦ Monitoring applied behavior analysis providers' provision of behavioral health treatment services according to the approved treatment plan, including reporting on authorized hours compared to utilized hours.
- ♦ Analyzing CalOptima's and its health networks' compliance with DHCS' access and availability standards.
- ♦ Conducting follow-up on discovery of providers' poor quality of care.

CalOptima's responses to the MCP's CAP resulted in DHCS closing the CAP.

During the 2020 A&I Medical and State Supported Services Audits of CalOptima, A&I identified a finding in only two categories (Access and Availability of Care and Member's Rights).

Opportunities for Improvement—Compliance Reviews

CalOptima has the opportunity to work with DHCS to ensure the MCP fully resolves the findings in the Access and Availability of Care and Member's Rights categories from the 2020 A&I Medical Audit. Specifically, CalOptima should ensure that the MCP:

- ♦ Analyzes each provider's compliance with the access wait time standards and implements CAPs for the providers when applicable.
- ♦ Properly classifies member grievances, immediately submits all quality of care grievances to its medical director for action, and completes the quality of service and quality of care grievance investigation processes before sending resolution letters to members.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures CalOptima chose to report using one or both of these two options.

[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of CalOptima, and the *HEDIS 2020 Compliance Audit Final Report of Findings for CalOptima* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that CalOptima followed the appropriate specifications to produce valid rates; however, the auditor also noted that although the MCP made improvements to its data reconciliation processes, which included documenting all data sources and providing initial and final file volumes and counts, as recommended last year, the MCP needs to document the reconciliation of file volumes and counts at each step of data migration.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for CalOptima's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CalOptima—Orange County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	56.97%
Childhood Immunization Status—Combination 10	44.99%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	94.29%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	88.41%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	91.42%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	88.80%

Measure	Reporting Year 2020 Rate
Developmental Screening in the First Three Years of Life—Total	16.35%
Immunizations for Adolescents—Combination 2	55.61%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	89.26%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	66.67%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	79.21%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CalOptima—Orange County

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	63.43%
Cervical Cancer Screening	66.67%
Chlamydia Screening in Women—Ages 16–20 Years	73.09%
Chlamydia Screening in Women—Ages 21–24 Years	74.36%
Chlamydia Screening in Women—Total	73.64%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	13.82%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.42%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.37%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.43%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	2.39%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.45%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	31.69%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	31.38%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	2.21%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.67%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	12.44%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	8.68%
Prenatal and Postpartum Care—Postpartum Care	83.21%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	95.13%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CalOptima—Orange County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	59.32%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	43.47%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	39.80%

Measure	Reporting Year 2020 Rate
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	47.39%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	34.47%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	13.33%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	21.71%

Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
CalOptima—Orange County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	96.00%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	34.98
Asthma Medication Ratio—Total	67.28%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	27.08%
Comprehensive Diabetes Care—HbA1c Testing—Total	89.32%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	14.64%

Measure	Reporting Year 2020 Rate
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	12.13%
Controlling High Blood Pressure—Total	72.81%
HIV Viral Load Suppression—Ages 18–64 Years	6.50%
HIV Viral Load Suppression—Ages 65+ Years	S
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.01%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.71%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.93
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	5.68%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	2.57%

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, CalOptima will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CalOptima—Orange County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	45.36	34.11	Not Tested	34.98
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	93.59%	94.30%	-0.71	94.29%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	89.46%	88.38%	1.08	88.41%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	87.19%	91.58%	-4.39	91.42%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	83.50%	89.00%	-5.50	88.80%
*Plan All-Cause Readmissions—Total***	12.02%	8.31%	3.71	9.01%

Seniors and Persons with Disabilities—Performance Measure Findings

HSAG observed the following notable results in reporting year 2020 for measures that CalOptima stratified by the SPD and non-SPD populations:

- Members ages 7–11 years and 12–19 years in the SPD population had significantly fewer instances of a visit with a primary care provider (PCP) during the measurement year than members in these age groups in the non-SPD population in reporting year 2020. The significant differences may be attributed to members ages 7 to 19 in the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from PCPs.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

CalOptima has the opportunity to improve its data reconciliation processes by documenting the file volume and count reconciliation at each step of data migration between the MCP's enterprise systems and the measure calculation tool, not just the initial and final volumes and counts.

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to CalOptima's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that CalOptima report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the reporting year 2020 rates for each required MLTSSP performance measure. Table 4.1 presents reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 4.1—Reporting Year 2020 MLTSSP Performance Measure Results
CalOptima—Orange County

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	60.39
*Plan All-Cause Readmissions—Observed Readmissions—Total***	14.01%
Plan All-Cause Readmissions—Expected Readmissions—Total	13.34%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.05

5. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, CalOptima submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, CalOptima initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, CalOptima identified poor control of diabetes (defined as an HbA1c level above 9 percent) among members residing in the city of Santa Ana as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure results reported by the MCP for its *Diabetes Poor HbA1c Control* Disparity PIP.

Table 5.1—CalOptima *Diabetes Poor HbA1c Control* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of poor or uncontrolled blood glucose levels (HbA1c > 9.0 percent) among members living with diabetes, 18 to 75 years of age, at two targeted provider offices in Santa Ana	62.50%	52.31%	Yes

Table 5.2 presents a description of the interventions that CalOptima tested for its *Diabetes Poor HbA1c Control* Disparity PIP. The table also indicates the key drivers and failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing each intervention.

Table 5.2—CalOptima *Diabetes Poor HbA1c Control* Disparity PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Use health coaches to outreach to members to encourage the use of CalOptima disease management services	♦ Member education ♦ Member engagement ♦ Member resources ♦ Members are not interested in understanding the information provided on diabetes management	Adapt
Obtain monthly data of provider offices A & B[6] to identify members needing their HbA1c tests and share this list with provider offices A & B to conduct outreach	♦ Provider awareness ♦ Identification of members with an HbA1c > 9.0 or missing the HbA1c test ♦ Provider does not promote the importance of HbA1c testing or educate the members on the importance of HbA1c testing	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CalOptima's *Diabetes Poor HbA1c Control* Disparity PIP. The MCP documented in the modules that it tested two interventions, telephonic provider outreach and health coaching. The provider outreach intervention included the MCP generating monthly lists of members who need an HbA1c test and providing the lists to provider offices. The provider outreached to members on the list to educate and promote the importance of getting an HbA1c test and to schedule an office visit. The health coaching intervention included the MCP health coach team telephonically outreaching to members and offering coaching services. If the member accepted, the health coach conducted an assessment and coached the member on diabetes management, including HbA1c testing. CalOptima achieved the SMART Aim goal in January

[6] Provider office names removed for confidentiality.

2019 with a rate of 40.74 percent; however, the tested interventions could not be linked to the demonstrated improvement.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CalOptima's *Diabetes Poor HbA1c Control* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Due to CalOptima demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. Based on its MCP-specific data, CalOptima selected adults' access to preventive and ambulatory health services as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure results as reported by the MCP for its *Adults' Access to Preventive and Ambulatory Health Services* PIP.

Table 5.3—CalOptima *Adults' Access to Preventive and Ambulatory Health Services* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of adults' access to preventive and ambulatory health services among members ages 45 to 64 assigned to two targeted provider offices	47.18%	78.02%	No

Table 5.4 presents a description of the interventions that CalOptima tested for its *Adults' Access to Preventive and Ambulatory Health Services* PIP. The table also indicates the key drivers and failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing each intervention.

Table 5.4—CalOptima *Adults' Access to Preventive and Ambulatory Health Services* PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide incentives to staff members at provider offices C & D[7] for being more proactive in outreach and for being more accurate and timelier in submitting claims/encounters for each visit	♦ Provider awareness ♦ Staffing resources/availability ♦ Provider office staff members are not engaged	Adapt
Provide incentives to members to attend and complete their preventive health care services at provider offices C & D	♦ Member resources ♦ Member is more concerned with social determinants than preventive health care services	Abandon

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CalOptima's *Adults' Access to Preventive and Ambulatory Health Services* PIP. The MCP tested two interventions to improve ambulatory and preventive health visit participation—a provider incentive program and a member incentive program. Both interventions included member outreach by the providers to schedule ambulatory or preventive visits. While CalOptima determined to adapt the provider incentive intervention, the MCP decided to abandon the member incentive intervention. Despite CalOptima' efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CalOptima's *Adults' Access to Preventive and Ambulatory Health Services* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS

[7] Provider office names removed for confidentiality.

encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, CalOptima identified acute or preventive care visits among members experiencing homelessness as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 through 3 for the MCP's *Primary Care Provider Visits* Health Equity PIP. Upon initial review, HSAG determined that CalOptima met some required validation criteria for modules 1 and 2; however, HSAG identified opportunities for improvement related to including:

- All required components of the SMART Aim data collection methodology.
- All required components of the SMART Aim.
- A process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.

After receiving technical assistance from HSAG, CalOptima incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. CalOptima met all Module 3 validation criteria in its initial submission.

Table 5.5 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the MCP's *Primary Care Provider Visits* Health Equity PIP.

Table 5.5—CalOptima *Primary Care Provider Visits* Health Equity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of acute and/or preventive care services among members 18 years and older identified as experiencing homelessness in Orange County	41.8%	43.2%

Table 5.6 presents a description of the intervention that CalOptima selected to test for its *Primary Care Provider Visits* Health Equity PIP. The table also indicates the failure mode that the intervention aims to address.

Table 5.6—CalOptima *Primary Care Provider Visits* Health Equity PIP Intervention Testing

Intervention	Failure Mode Addressed
Implement the Homeless Clinical Access Program to increase access to acute/preventive care services through mobile clinics for members 18 years and older experiencing homelessness	Member does not attend appointment/access because it is not convenient

While CalOptima advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, CalOptima selected well-child visits in the first 15 months of life as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 through 3 for the MCP's *Well-Child Visits in the First 15 Months of Life* PIP. Upon initial review, HSAG determined that CalOptima met some required validation criteria for modules 1 and 3; however, HSAG identified opportunities for improvement related to:

- ♦ Including all required components of the SMART Aim data collection methodology.
- ♦ Ensuring that the intervention effectiveness measure was appropriate for the intervention.

After receiving technical assistance from HSAG, CalOptima incorporated HSAG's feedback into modules 1 and 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 3. CalOptima met all Module 2 validation criteria in its initial submission.

Table 5.7 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the *Well-Child Visits in the First 15 Months of Life* PIP.

Table 5.7—CalOptima *Well-Child Visits in the First 15 Months of Life* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of well-child visit completion among members turning 15 months old for Provider Office E[8]	41.51%	51.61%

Table 5.8 presents a description of the intervention that CalOptima selected to test for its *Well-Child Visits in the First 15 Months of Life* PIP. The table also indicates the failure modes that the intervention aims to address.

Table 5.8—CalOptima *Well-Child Visits in the First 15 Months of Life* PIP Intervention Testing

Intervention	Failure Modes Addressed
Implement provider incentive program to encourage provider office staff members to conduct outreach and schedule well-child visits for members	♦ Provider office does not engage in outreach activities ♦ Provider office does not complete at least six well-child visits before the member's 15-month birthday

While CalOptima advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, CalOptima identified interventions that it can adapt to improve diabetes control for its members and access to preventive care and ambulatory services for the MCP's adult members.

Opportunities for Improvement—Performance Improvement Projects

CalOptima has the opportunity to monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs. The MCP should apply lessons learned from these PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.

[8] Provider office name removed for confidentiality.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the

statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSP to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

CalOptima submitted the MCP's final PNA report to DHCS on August 13, 2020, and DHCS notified the MCP via email on August 17, 2020, that DHCS approved the report as submitted. While CalOptima submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from CalOptima's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of CalOptima's self-reported actions.

Table 8.1—CalOptima's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP fully resolves all findings from the February 2019 Medical and State Supported Services Audits.	CalOptima worked with DHCS to ensure the complete resolution of its findings from the 2019 DHCS Medical and State Supported Services Audits. On March 20, 2020, DHCS formally closed CalOptima's CAP following the submission and verification of various supporting documentation, including but not limited to reports, desktops, updated polices, and evidence of training. Please note that CalOptima did not receive any findings with respect to the State Supported Services portion of the audits.
2. Improve the MCP's processes for how it ensures that the MCP's systems accurately reflect providers' relationships with federally qualified health centers (FQHCs) and that the MCP's data mapping accurately reflects the relationships at the provider and FQHC levels. In particular, the MCP should ensure that its data mapping	CalOptima follows NCQA's definition regarding FQHCs and develops a scope and design document that outlines the verification process to map FQHCs to PCPs. This document is reviewed and approved by an NCQA-certified auditor prior to the mapping being applied for HEDIS reporting.

2018–19 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
accurately reflects instances for which the FQHC is mapped as a PCP.	
3. Develop a process to systematically document all data sources and track data volume counts from the point of entry into the MCP's enterprise systems to the point of inputting the data in the measure calculation tool. Additionally, document all data sources in the Roadmap so that the auditor has complete information to review during the approval process.	Queries have been formulated to track volumes of data sources. Discrepancies between the data warehouse and the HEDIS repository are members who do not qualify for HEDIS reporting. All data sources in the Roadmap are documented with appropriate Microsoft SharePoint documentation, and they are reviewed and approved by an NCQA-certified HEDIS auditor.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CalOptima's self-reported actions in Table 8.1 and determined that CalOptima adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. CalOptima noted the documentation the MCP submitted to DHCS to fully resolve the findings from the February 2019 A&I Medical and State Supported Services Audits. Additionally, CalOptima described the changes the MCP made to strengthen its processes for the performance measure validation audit, which were reviewed and approved by the HSAG auditor.

2019–20 Recommendations

Based on the overall assessment of CalOptima's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to ensure the MCP fully resolves the findings from the 2020 A&I Medical Audit regarding the MCP:
  - Analyzing each provider's compliance with the access wait time standards and implementing CAPs for the providers when applicable.
  - Properly classifying member grievances, immediately submitting all quality of care grievances to its medical director for action, and completing the quality of service and quality of care grievance investigation processes before sending resolution letters to members.

- Improve its data reconciliation processes by documenting the file volume and count reconciliation at each step of data migration between the MCP's enterprise systems and the measure calculation tool, not just the initial and final volumes and counts.
- Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs.
- Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.

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

Medi-Cal Managed Care External Quality Review Technical Report

Appendix I: Performance Evaluation Report CalViva Health

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, CalViva Health ("CalViva" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in CalViva's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CalViva is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in CalViva, the Local Initiative MCP, or in Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, the alternative commercial plan.

CalViva became operational in Fresno, Kings, and Madera counties to provide MCMC services effective March 2011. As of June 2020, CalViva had 289,126 members in Fresno County, 30,421 in Kings County, and 38,457 in Madera County—for a total of 358,004 members.[1] This represents 73 percent of the beneficiaries enrolled in Fresno County, 61 percent in Kings County, and 65 percent in Madera County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CalViva. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CalViva. A&I conducted the audits from February 25, 2019, through March 1, 2019.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CalViva
Audit Review Period: April 1, 2018, through January 31, 2019

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

Table 2.2 summarizes the results and status of the on-site DHCS A&I Medical and State Supported Services Audits of CalViva conducted from February 3, 2020, through February 14, 2020. The Medical Audit portion was a reduced scope audit, evaluating five categories rather than six.

Table 2.2—DHCS A&I Medical and State Supported Services Audits of CalViva Audit Review Period: February 1, 2019, through January 31, 2020

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

Strengths—Compliance Reviews

During the 2019 Medical and State Supported Services Audits of CalViva, A&I identified no findings in five of the seven categories evaluated. Additionally, in response to the CAP from these audits, CalViva provided documentation to DHCS regarding changes the MCP made to policies and procedures related to the findings A&I identified in the Utilization Management and Member's Rights categories. Upon review of CalViva's documentation, DHCS closed the CAP.

During the 2020 Medical and State Supported Services Audits of CalViva, A&I identified no findings in four of the six categories evaluated.

Opportunities for Improvement—Compliance Reviews

CalViva has the opportunity to work with DHCS to ensure that the MCP fully resolves the findings from the 2020 Medical Audit of CalViva by:

- Developing and implementing effective follow-up procedures to ensure the MCP's compliance with ensuring providers complete Individual Health Education Behavior Assessments (IHEBAs) as part of the Initial Health Assessments (IHAs).
- Developing and implementing policies and procedures to ensure the MCP's provider network provides timely access for members.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures CalViva chose to report using one or both of these two options.

[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- ♦ Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- ♦ Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of CalViva, and the *HEDIS 2020 Compliance Audit Final Report of Findings for CalViva Health* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that CalViva followed the appropriate specifications to produce valid rates; however, during primary source verification of a sample of randomly selected dual eligibility exclusions, the auditor noted that several members only had dual eligible coverage during part of the measurement year. The auditor indicated that to comply with NCQA's General Guideline 15 wherein exclusions are to be applied according to the continuous enrollment requirements for each measure, CalViva should implement dual eligibility calculations in monthly enrollment spans.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.12 for CalViva's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.12:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 through Table 3.3 present the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CalViva—Fresno County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	53.77%
Childhood Immunization Status—Combination 10	33.82%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	95.40%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	87.10%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	87.91%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	85.94%

Measure	Reporting Year 2020 Rate
Developmental Screening in the First Three Years of Life—Total	34.22%
Immunizations for Adolescents—Combination 2	38.69%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	82.73%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	56.45%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.85%

Table 3.2—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CalViva—Kings County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	63.75%
Childhood Immunization Status—Combination 10	33.09%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	93.44%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	87.35%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	88.25%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	85.24%
Developmental Screening in the First Three Years of Life—Total	25.12%
Immunizations for Adolescents—Combination 2	35.04%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	91.73%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	62.53%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.68%

Table 3.3—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CalViva—Madera County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	64.23%
Childhood Immunization Status—Combination 10	46.96%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	97.51%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	92.19%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	92.99%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	91.21%
Developmental Screening in the First Three Years of Life—Total	52.51%
Immunizations for Adolescents—Combination 2	54.88%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	95.38%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	70.07%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	83.57%

Women's Health Domain

Results—Women's Health Domain

Table 3.4 through Table 3.6 present the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.4—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CalViva—Fresno County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	55.26%
Cervical Cancer Screening	63.50%
Chlamydia Screening in Women—Ages 16–20 Years	54.00%
Chlamydia Screening in Women—Ages 21–24 Years	68.09%
Chlamydia Screening in Women—Total	61.26%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	16.68%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	29.21%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.12%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.56%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	7.84%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	40.76%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	38.68%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.92%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	10.38%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	7.01%
Prenatal and Postpartum Care—Postpartum Care	78.83%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	92.21%

Table 3.5—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CalViva—Kings County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	57.30%
Cervical Cancer Screening	70.07%
Chlamydia Screening in Women—Ages 16–20 Years	55.38%
Chlamydia Screening in Women—Ages 21–24 Years	73.90%
Chlamydia Screening in Women—Total	64.48%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.69%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	28.40%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.95%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.39%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.80%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	38.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	45.60%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	13.19%

Measure	Reporting Year 2020 Rate
Prenatal and Postpartum Care—Postpartum Care	86.13%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	95.38%

Table 3.6—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CalViva—Madera County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	62.44%
Cervical Cancer Screening	65.21%
Chlamydia Screening in Women—Ages 16–20 Years	47.81%
Chlamydia Screening in Women—Ages 21–24 Years	65.04%
Chlamydia Screening in Women—Total	55.42%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.97%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	29.24%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.08%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.46%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.91%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	36.84%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.39%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.35%
Prenatal and Postpartum Care—Postpartum Care	81.51%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.48%

Assessment of Improvement Plans—Women's Health Domain

In April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that CalViva conducted as part of its IP prior to April 2020.

In reporting year 2019, the rate for the *Breast Cancer Screening* measure was below the minimum performance level in Fresno County, and DHCS approved CalViva to conduct a *Breast Cancer Screening* Health Equity PIP in place of conducting PDSA cycles to improve the MCP's performance on this measure. HSAG includes a summary of CalViva's progress on the *Breast Cancer Screening* Health Equity PIP in Section 4 of this report ("Performance Improvement Projects").

DHCS did not hold MCPs accountable to meet the minimum performance level for the *Breast Cancer Screening* measure in reporting year 2020; therefore, HSAG makes no assessment of CalViva's performance related to this measure.

Behavioral Health Domain

Table 3.7 through Table 3.9 present the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.7—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CalViva—Fresno County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	48.20%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	31.84%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	35.39%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	39.16%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.13%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.30%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Table 3.8—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CalViva—Kings County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	43.72%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	29.55%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	41.86%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA

Measure	Reporting Year 2020 Rate
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.00%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	S
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%

Table 3.9—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CalViva—Madera County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	47.74%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	27.44%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	44.78%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	S
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.10 through Table 3.12 present the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.10—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
CalViva—Fresno County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	90.75%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	48.71
Asthma Medication Ratio—Total	64.16%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	34.06%
Comprehensive Diabetes Care—HbA1c Testing—Total	87.83%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	13.67%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	7.41%
Controlling High Blood Pressure—Total	62.03%
HIV Viral Load Suppression—Ages 18–64 Years	S
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.33%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.41%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.10

Measure	Reporting Year 2020 Rate
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.57%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	0.00%

Table 3.11—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
CalViva—Kings County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	95.13%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	51.34
Asthma Medication Ratio—Total	71.17%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	35.77%
Comprehensive Diabetes Care—HbA1c Testing—Total	91.24%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	19.96%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	64.43%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.78%
Plan All-Cause Readmissions—Expected Readmissions—Total	8.72%

Measure	Reporting Year 2020 Rate
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.24
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.12—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
CalViva—Madera County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	94.65%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	45.66
Asthma Medication Ratio—Total	69.75%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	36.25%
Comprehensive Diabetes Care—HbA1c Testing—Total	93.43%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.12%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	69.77%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.53%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.30%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.92

Measure	Reporting Year 2020 Rate
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.96%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Assessment of Improvement Plans—Acute and Chronic Disease Management Domain

As previously stated, in April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that CalViva conducted as part of its IP prior to April 2020.

In reporting year 2019, the rate for the *Comprehensive Diabetes Care—HbA1c Testing—Total* measure was below the minimum performance level in Fresno County. DHCS approved CalViva to conduct PDSA cycles to address the MCP's performance below the minimum performance level for this measure.

CalViva tested whether having the panel manager implement planned care visits at two partner clinic sites by using a diabetes call script and following the Planned Care Visit Workflow would result in more members completing their HbA1c lab testing. The panel manager used the diabetes call script when reaching out to targeted members who needed to complete their required HbA1c testing. The MCP set the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objective for the PDSA cycle to be that 50 percent of the targeted members who heard the entire script would complete their HbA1c labs. The MCP reported that it exceeded the SMART objective by 12 percentage points, with 40 of the 65 members who heard the entire script completing their labs.

CalViva reported learning that receiving data from the clinic at designated intervals throughout the PDSA cycle and obtaining staff members' feedback biweekly allowed the MCP to address issues, challenges, and barriers in a timely manner. Additionally, having a clinic champion and support from quality improvement leadership increased the success of the intervention.

DHCS did not hold MCP's accountable to meet the minimum performance level for the *Comprehensive Diabetes Care—HbA1c Testing—Total* measure in reporting year 2020; therefore, HSAG makes no assessment of CalViva's performance related to this measure.

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the “Reporting Year 2020 Quality Monitoring and Corrective Action Plans” heading in this section, CalViva will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP’s strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.13 through Table 3.15 present the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.13—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CalViva—Fresno County

[green] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

[red] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit’s total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member’s “contribution” to the total yearly membership.

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	78.14	46.72	Not Tested	48.71
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	98.25%	95.38%	2.87	95.40%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	91.93%	86.97%	4.96	87.10%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	92.64%	87.74%	4.90	87.91%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	90.18%	85.79%	4.39	85.94%
*Plan All-Cause Readmissions—Total***	14.97%	8.35%	6.62	10.33%

Table 3.14—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CalViva—Kings County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	103.47	48.00	Not Tested	51.34
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	93.42%	Not Comparable	93.44%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	92.63%	87.19%	5.44	87.35%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	88.19%	88.26%	-0.07	88.25%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	88.17%	85.12%	3.05	85.24%
*Plan All-Cause Readmissions—Total***	12.96%	10.00%	2.96	10.78%

Table 3.15—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CalViva—Madera County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	79.79	44.08	Not Tested	45.66
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	97.49%	Not Comparable	97.51%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	96.08%	92.11%	3.97	92.19%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	98.41%	92.84%	5.57	92.99%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	94.48%	91.13%	3.35	91.21%
*Plan All-Cause Readmissions—Total***	NA	7.97%	Not Comparable	8.53%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that CalViva stratified by the SPD and non-SPD populations and for which HSAG could compare the reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results:

- The reporting year 2020 SPD rates were significantly better than the reporting year 2020 non-SPD rates for the following measures:

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years* in Fresno County
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years* in Fresno and Madera counties
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years* in Fresno County

♦ In Fresno County, the SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that CalViva followed the appropriate specifications to produce valid rates.

Opportunities for Improvement—Performance Measures

CalViva has the opportunity to update its enrollment determinations to monthly spans and implement dual eligibility calculations to ensure that dual eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, CalViva submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, CalViva initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, CalViva identified postpartum care in Fresno County as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure results reported by the MCP for its *Postpartum Care* Disparity PIP.

Table 4.1—CalViva *Postpartum Care* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of postpartum visit completion among members at a high-volume, low-compliance clinic in Fresno County	50%	64%	Yes

Table 4.2 presents a description of the interventions that CalViva tested for its *Postpartum Care* Disparity PIP. The table also indicates the key drivers and failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—CalViva *Postpartum Care* Disparity PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide a color-coded postpartum visit alert in the electronic health record (EHR) and appointment scheduling system indicating "schedule postpartum visit 21 to 56 days after delivery" to provide staff members with the correct time frame for the visit when the staff members need the information	♦ Providers and clinic staff members may not be aware of HEDIS postpartum visit time frames ♦ Front office staff members do not schedule postpartum visits within the correct time frame of 21 to 56 days ♦ Call center staff members do not schedule postpartum visits within the 21-to-56-day time frame	Adopt
Revise the obstetric history form to include a question on members' cultural preferences	♦ Existing process does not address cultural issues during the postpartum period	Adopt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CalViva's *Postpartum Care* Disparity PIP. In the modules, CalViva documented that it tested using color-coded alerts in the EHRs and appointment scheduling system to indicate that postpartum visits needed to be scheduled. The MCP tested the intervention in four cycles between August 2018 through June 2019. The MCP documented that appointment alerts were placed for 71 out of 103 members, and initial data showed that approximately 75 percent of members with an alert completed their postpartum visit. The MCP determined to adopt the color-coded alert intervention. In the modules, CalViva also documented that it tested revising the obstetric history form to include a question about members' cultural preferences. The MCP tested this intervention from October 2018 to June 2019. CalViva documented that 128 out of 185 members completed cultural preference documentation, and the MCP determined to adopt this intervention as well.

CalViva documented in the SMART Aim run chart that the MCP met the SMART Aim goal in July 2017, prior to beginning the intervention testing; however, the SMART Aim measure rate continued to improve throughout the intervention testing period, with the highest SMART Aim measure rate of 82 percent occurring in both March 2019 and April 2019.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CalViva's *Postpartum Care* Disparity PIP a final confidence level of *Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on CalViva's reporting year 2017 performance measure results, the MCP selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure results as reported by the MCP for its *Childhood Immunization Status—Combination 3* PIP.

Table 4.3—CalViva *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of *Childhood Immunization Status—Combination 3* measure compliance among members assigned to Health Center A[6] in Fresno County	48.7%	60.0%	Yes

Table 4.4 presents a description of the interventions that CalViva tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the key drivers and/or failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.4—CalViva *Childhood Immunization Status—Combination 3* PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Eliminate the double-booking option for provider scheduling to allow for additional appointment slots for members to get their needed immunization appointments	♦ Scheduling process ♦ Rescheduling/appointment availability/timing ♦ Phone system ♦ Members wait too long to schedule an appointment	Adapt

[6] Health center name removed for confidentiality.

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide $25 Visa gift card member incentives for completing immunizations	♦ Transportation ♦ Child care ♦ Family obligations	Adopt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CalViva's *Childhood Immunization Status—Combination 3* PIP. In the modules, CalViva documented that it tested eliminating double-booking options for providers between August 2018 through December 2018. Initially, CalViva planned to eliminate the double-booking option and allow for walk-ins/same-day call request bookings as the MCP anticipated high utilization of walk-ins/same-day bookings. When CalViva realized the walk-in/same-day bookings options were not used, the MCP revised the intervention to have the provider staff members outreach to members' parents/guardians and offer them an appointment time with the registered nurse (RN) or the provider that was convenient for the member. The MCP reported that the no-show rate decreased as a result of this intervention and determined to adapt this intervention. In the modules, CalViva also documented that it tested a member incentive intervention starting in December 2018. The MCP offered a $25 gift card per member per visit at the point of care for completing immunizations. CalViva documented distributing 40 gift cards from December 2018 through June 2019. The MCP determined to adopt the gift card incentive intervention.

CalViva documented in the SMART Aim run chart that the MCP met the SMART Aim goal in July 2018, prior to the intervention testing began; however, the SMART Aim measure rate continued to improve throughout the intervention testing period, with the highest SMART Aim measure rate occurring in April 2019.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CalViva's *Childhood Immunization Status—Combination 3* PIP a final confidence level of *Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, CalViva identified breast cancer screening among Hmong-speaking members as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 through 3 for the MCP's *Breast Cancer Screening* Health Equity PIP. Upon initial review of the modules, HSAG determined that CalViva met all validation criteria for Module 1. The MCP met some required validation criteria in its initial submissions of modules 2 and 3; however, HSAG identified opportunities for improvement related to:

- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.
- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.
- Ensuring that the data collection process was appropriate for the intervention effectiveness measure.

After receiving technical assistance from HSAG, CalViva incorporated HSAG's feedback into modules 2 and 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 2 and 3.

Table 4.5 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the MCP's *Breast Cancer Screening* Health Equity PIP.

Table 4.5—CalViva *Breast Cancer Screening* Health Equity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of breast cancer screening among Hmong-speaking members assigned to the Health Organization A[7] sites in Fresno County	19.2%	28.8%

Table 4.6 presents a description of the intervention that CalViva selected to test for its *Breast Cancer Screening* Health Equity PIP. The table also indicates the failure mode that the intervention aims to address.

[7] Health organization name removed for confidentiality.

Table 4.6—CalViva Health Equity PIP Intervention Testing

Intervention	Failure Mode Addressed
Implement the Hmong Sisters Health Education Event which educates participants regarding the importance of breast cancer screening and provides transportation services to the imaging center for participants to complete breast cancer screening exams	Members refuse breast cancer screening exam

While CalViva advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, CalViva determined to continue to focus on childhood immunizations for its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Childhood Immunization Status—Combination 10* PIP. CalViva met all validation criteria for both modules 1 and 2 in its initial submissions. CalViva was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

CalViva achieved the SMART Aim goal for both 2017–19 PIPs, and some of the quality improvement activities could be linked to the demonstrated improvement. Based on its assessment, HSAG assigned the 2017–19 *Postpartum Care* Disparity PIP and *Childhood Immunization Status—Combination 3* PIP each a final confidence level of *Confidence*.

Opportunities for Improvement—Performance Improvement Projects

CalViva has the opportunity to continue monitoring adopted and adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 PIPs. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

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

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

CalViva submitted the MCP's PNA report to DHCS on June 30, 2020, and DHCS notified the MCP via email on July 17, 2020, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 7.1 provides EQR recommendations from CalViva's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of CalViva's self-reported actions.

Table 7.1—CalViva's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. To improve the MCP's performance to above the minimum performance levels for the *Breast Cancer Screening* and *Comprehensive Diabetes Care—HbA1c Testing* measures in Fresno County, assess whether the MCP should make changes to its current improvement strategies to address the factors contributing to the MCP's performance below the minimum performance levels. (The rates for these measures were also below the minimum performance levels in reporting year 2018 for Fresno County.)	During the 2019–20 intervention period, CalViva reexamined the barriers associated with the two measures which indicated performance below the minimum performance levels in Fresno County: ♦ *Breast Cancer Screening* ♦ *Comprehensive Diabetes Care—HbA1c Testing* CalViva conducted quarterly PDSA cycles and for the *Breast Cancer Screening* measure initiated a new PIP in an effort to improve outcomes for both measures. ***Breast Cancer Screening*** Although we did see great success with our mobile mammography events in 2019 using our member-centered approach, we only saw moderate improvements in our overall *Breast Cancer Screening* measure rates. Our ability to impact overall rates was limited by the fact that we were focused on the sub-group of Hmong women and although we started planning events in 2018, they actually occurred in 2019. We have also learned that the patient-centered approach we employed for Hmong women can be extrapolated to other cultures and languages. Finally,

<table>
<tr><th>2018–19 External Quality Review Recommendations Directed to CalViva</th><th>Self-Reported Actions Taken by CalViva during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations</th></tr>
<tr><td></td><td>we recognized that mobile mammography is not a long-term solution for the MCP. We need to identify the barriers to women completing a mammogram at their local imaging center, especially for women of diverse cultures and languages. Taking all of this into consideration, the interventions for the Breast Cancer Screening measure included:
♦ Submission on July 19, 2019, of a proposal for the 2019–21 Health Equity PIP on breast cancer screening in Fresno County. Our data analysis revealed that members receiving breast cancer screenings who spoke Hmong were statistically less likely to have completed a screening in reporting year 2019 than members completing a screening who spoke English.
♦ On October 4, 2019, a multidisciplinary Breast Cancer Improvement Team was formed in collaboration with the targeted federally qualified health center (FQHC) when CalViva met with the FQHC for its annual clinic visit. Module 1 development began at this time.
♦ Module 1 PIP Initiation development included:
■ Team membership which includes the Fresno Center (local community-based organization), a women's imaging center, the clinic, and the MCP (MD [medical doctor], RN, quality improvement, health education, data analysts, and Cultural & Linguistics staff members).
■ Data analysis demonstrating a statistically significant difference between English and Hmong speakers.
■ Barrier analysis information that was gathered through key informant interviews and focus groups.
■ SMART Aim definition—establishing the specific goal of the team.
Module 1 was submitted on October 25, 2019, and approved on November 15, 2019.</td></tr>
</table>

2018–19 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ Module 2 Intervention Determination efforts were initiated right away as this module requires a significant number of hours by the PIP Team to successfully complete and includes the following: ■ *Process Mapping*—This “map” outlines each step in the process from the patient perspective. It also identifies the gaps or opportunities for improvement in the process. ■ *Failure Modes and Effects Analysis*—Ranks the potential failures in the process to assist with prioritizing which failures to address first. The team identified “Understanding the Importance of Breast Cancer Screening” (by the member) as the top priority for improvement. ■ *Key Driver Diagram*—Provides a visual representation of project goals, factors/issues/problems impacting success, and potential interventions to address these issues. Initial submission of Module 2 was on January 17, 2020, and it was approved on February 28, 2020. ♦ Module 3 Intervention Testing involves the development of a comprehensive, step-by-step plan to implement the first intervention for improvement. Appropriate intervention effectiveness measures are established along with a data collection methodology. Module 3 was submitted on April 24, 2020, and approved on June 8, 2020. Due to the public health crisis associated with COVID-19, on June 22, 2020, DHCS ended the PIPs and indicated that DHCS would have MCPs initiate new PIPs in mid-to-late summer. In addition, from July 1, 2019, to June 30, 2020, CalViva partnered with the mobile mammography vendor to deploy the unit to 22 additional sites within Fresno County (providers and community locations)

2018–19 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	and screened 448 members. The 22 events were held between July 19, 2019, and February 26, 2020. CalViva also partnered with Susan G. Komen to target non-compliant members residing in Fresno County. Susan G. Komen staff assisted members in scheduling appointments for mobile mammography events. Members who were scheduled and completed their mobile mammography appointments were awarded a member incentive of a $25 Visa gift card. From July 1, 2019, to June 30, 2020, CalViva completed 10 Susan G. Komen events, screening 87 members. The events were held on the following dates: ♦ August 13 and 14, 2019 ♦ September 20 and 30, 2019 ♦ October 23 and 24, 2019 ♦ February 1, 2, and 29, 2020 ♦ March 1, 2020 ***Comprehensive Diabetes Care—HbA1c Testing*** The CalViva Diabetes Improvement Team utilized recommendations from the Institute for Healthcare Improvement (IHI) Chronic Disease Toolkit "Partnering in Self-management" to provide a framework for diabetes improvement efforts during the past year. ♦ From July to December 2019, building on previous improvement strategies, the team performed PDSA cycles to confirm the effectiveness of "The Planned Care Visit" approach. This approach emphasizes preparing the diabetic patient for a successful office visit by using the Diabetes Call Script, *Comprehensive Diabetes Care* HEDIS Workflow for Nephropathy, and the clinic's Planned Care Visit Workflow. Initial results were very strong, with 82 percent (45/55) of members

2018–19 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	scheduling an appointment and/or having labs drawn/ordered. ♦ For 2020, the CalViva Diabetes Improvement Team had plans to add a new educational component: ■ The Planned Care Visit (PCV) process to continue with telephonic outreach by the clinic panel manager. ■ Lab testing to be scheduled via the PCV process. Member reminders for lab test. ■ HbA1c test performed at point of care so the member receives immediate result. ■ Licensed vocational nurse (LVN) education at the time of the HbA1c test, using a Stoplight Tool approved by CMS and based on the results of the test. ■ Appointment with provider scheduled and reinforced with the member the need to attend the appointment (appointments scheduled sooner for members with high HbA1c, result >9). ♦ Due to the COVID-19 public health emergency, CalViva was unable to implement and test the 2020 strategies with the targeted provider. DHCS did not require submission of the final 2020 PDSA cycle for diabetes. In 2019, CalViva also deployed an in-home screening program in collaboration with MedXM to assist members in accessing services to complete their required lab screenings. In Fresno County, 1,208 HbA1c tests were completed through the in-home screening program from July 1, 2019, through December 31, 2019. In 2020, in-home testing was cancelled due to the COVID-19 pandemic. **Multi-Measure Actions** A collaborative effort between CalViva's quality improvement, provider relations, and health education staff members to partner with providers to host weekend and extended hours clinics in 2019

2018–19 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	addressed barriers and gaps in care for members. The events offered care for several measures including *Breast Cancer Screening* and *Comprehensive Diabetes Care*. In 2020, one clinic day was completed, and all other clinic days were cancelled due to the COVID-19 pandemic.
2. For the following measures, identify the causes for the significant decline in the MCP's performance from reporting year 2018 to 2019 and, as applicable, identify strategies to address the decline in performance:	
♦ *Asthma Medication Ratio* in Fresno County	***Asthma Medication Ratio*** CalViva has assessed the causes and significant issues driving declining performance for the *Asthma Medication Ratio* measure in Fresno County. ♦ Lack of provider knowledge and training on HEDIS technical specifications and requirements. ♦ Lack of member education on asthma medications and their appropriate use (controller versus reliever). The issues above led to the following scenarios impacting the *Asthma Medication Ratio* measure rates in Fresno County: ♦ Members are getting reliever and controller medications; however, the ratio is not equal. The volume of reliever medications far exceeds the controllers. ♦ Members are only picking up reliever medications. There were no prescriptions for controllers. ♦ Members do not have any medications. CalViva applied lessons learned from quality improvement activities to apply strategies to improve MCP performance. Strategies include: ♦ Improve provider understanding of HEDIS technical specifications and appropriate prescriptions.

2018–19 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ Improve member engagement via member outreach, education, pharmacy reminders, and appointment scheduling.
♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* in Madera County	CalViva has assessed the multiple causes and significant issues driving declining performance for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure in Madera County. According to the reporting year 2020 HEDIS reason code analysis, which identifies barriers to compliance through medical record review, the primary reasons for non-compliance in Madera County were: ♦ Members' HbA1c values were out of range, indicating members require education and are not adequately informed about their condition in order to take an active role in their treatment. ♦ No HbA1c test was performed during the measurement year, and no value was found for the dates of service, demonstrating a lack of provider/office knowledge on appropriate coding for HbA1c results and a need for training on HEDIS technical specifications and requirements. ♦ Inconsistent data sharing between the MCP and provider due to no medical record received for the member during medical record retrieval. CalViva has applied lessons learned from quality improvement activities to strategies to improve MCP performance. Strategies include: ♦ Improve access to care for members through: ■ Standing orders for labs ■ In-home visits ■ Lab concierge ♦ Improve provider understanding of HEDIS technical specifications, including codes for HbA1c results, through tailored provider trainings (in-person and virtual) for providers with year-over-year low compliance.

2018–19 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ Improve data sharing between CalViva and the provider. ♦ Share member care gap reports that help identify non-compliant members via multiple methods (i.e., provider portal, secure email, and printed reports), and coach office staff members on best practices for targeted outreach for members with values out of range. ♦ Collaborate with provider offices on opportunities for improved EHR capture (i.e., Cozeva). ♦ Improve member engagement via member outreach reminders and appointment scheduling. ♦ Offer member incentives for low-scoring measures.
♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in Fresno County	CalViva has assessed the multiple causes and significant issues driving declining performance for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in Fresno County. According to the reporting year 2020 HEDIS reason code analysis, which identifies barriers to compliance through medical record review, the primary reasons for non-compliance in Fresno County were: ♦ Record was received but was missing one or more components for overall compliance, or no compliant data were found in the record, indicating lack of provider knowledge and need for training on HEDIS technical specifications and requirements for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. ♦ No record received by the MCP demonstrates additional opportunities to improve data sharing between CalViva and the provider, as well as the continued importance of training around coding for the measure. ♦ Lack of member education on health care topics and recommended screenings.

2018–19 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	CalViva applied lessons learned from quality improvement activities to strategies to improve MCP performance. Strategies include: ♦ Improve access to care for members through collaboration with clinics to host expanded-hour clinics and clinic events. ♦ Improve provider understanding of HEDIS technical specifications, administrative data capture, and discontinuation of the PM160 forms. ♦ Improve data sharing between CalViva and the provider (i.e., member care gap reports that help identify non-compliant members, transition from PM160 forms to administrative data capture). ♦ Collaborate with provider offices on opportunities for improved EHR capture (i.e., Cozeva). ♦ Improve member engagement via member outreach, reminders, and appointment scheduling.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CalViva's self-reported actions in Table 7.1 and determined that CalViva adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. CalViva described in detail actions taken during the review period, results from the MCP's assessment of declining performance and performance below the minimum performance levels, lessons learned, and steps the MCP plans to take moving forward. CalViva described specific interventions and strategies it implemented to improve performance to above the minimum performance levels or prevent further decline in performance.

2019–20 Recommendations

Based on the overall assessment of CalViva's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to ensure that the MCP fully resolves the findings from the 2020 Medical Audit of CalViva by:
  - Developing and implementing effective follow-up procedures to ensure the MCP's compliance with ensuring providers complete IHEBAs as part of the IHAs.

- Developing and implementing policies and procedures to ensure the MCP's provider network provides timely access for members.

♦ Update the MCP's enrollment determinations to monthly spans and implement dual eligibility calculations to ensure that dual eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.

♦ Continue monitoring adopted and adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 PIPs.

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

Medi-Cal Managed Care External Quality Review Technical Report

Appendix J: Performance Evaluation Report CenCal Health

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, CenCal Health ("CenCal" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in CenCal's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CenCal is a full-scope MCP delivering services to its members in the County Organized Health System model.

CenCal became operational to provide MCMC services in Santa Barbara County effective September 1983 and San Luis Obispo County in March 2008. As of June 2020, CenCal had 128,610 members in Santa Barbara County and 53,279 in San Luis Obispo County—for a total of 181,889 members.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CenCal.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CenCal. A&I conducted the audits from November 4, 2019, through November 15, 2019. A&I assessed CenCal's compliance with its DHCS contract and determined to what extent the MCP had implemented its corrective action plan (CAP) from the 2018 Medical Audit. DHCS issued the final closeout letter on October 15, 2020, which is outside the review dates for this report; however, HSAG includes the information from the letter because it reflects full resolution of the findings from the 2019 A&I Medical Audit.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CenCal
Audit Review Period: November 1, 2018, through October 31, 2019

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

Follow-Up on 2018 A&I Medical Audit of CenCal

A&I conducted a Medical Audit of CenCal from November 6, 2018, through November 8, 2018, covering the review period of November 1, 2017, through October 31, 2018. HSAG provided a summary of the audit results and status in CenCal's 2018–19 MCP-specific evaluation report. At the time the evaluation report was published, CenCal's CAP was in progress and under review by DHCS. A letter from DHCS dated June 2, 2020, stated that CenCal provided DHCS with additional information regarding the CAP, and that DHCS had reviewed the information and closed the CAP. The letter indicated that DHCS would monitor the MCP's full implementation of the CAP during the subsequent audit.

Strengths—Compliance Reviews

A&I identified no findings in the Quality Management, Administrative and Organizational Capacity, and State Supported Services categories during the 2019 Medical and State Supported Services Audits of CenCal. In response to the CAPs from the 2018 and 2019 A&I Medical Audits of CenCal, the MCP provided documentation to DHCS that resulted in the CAPs being closed. CenCal's documentation reflected changes to policies and procedures to ensure the MCP is compliant with DHCS' standards in all categories in which A&I identified findings during the 2018 and 2019 audits.

Opportunities for Improvement—Compliance Reviews

CenCal has no outstanding findings from the 2018 or 2019 A&I Medical Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures CenCal chose to report using one or both of these two options.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- ♦ Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- ♦ Additional technical assistance calls with DHCS Nurse Consultant staff.
- ♦ In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of CenCal, and the *HEDIS 2020 Compliance Audit Final Report of Findings for CenCal Health* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.8 for CenCal's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.8:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 and Table 3.2 present the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CenCal—San Luis Obispo County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	57.18%
Childhood Immunization Status—Combination 10	50.61%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	96.28%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	90.41%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	92.36%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	91.29%

Measure	Reporting Year 2020 Rate
Developmental Screening in the First Three Years of Life—Total	19.00%
Immunizations for Adolescents—Combination 2	44.77%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	90.75%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	63.02%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.32%

Table 3.2—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CenCal—Santa Barbara County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	59.37%
Childhood Immunization Status—Combination 10	50.61%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	96.97%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	92.12%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	94.08%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	91.27%
Developmental Screening in the First Three Years of Life—Total	20.24%
Immunizations for Adolescents—Combination 2	55.72%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	90.75%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	68.13%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	85.19%

Women's Health Domain

Table 3.3 and Table 3.4 present the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.3—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CenCal—San Luis Obispo County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	63.06%
Cervical Cancer Screening	67.15%
Chlamydia Screening in Women—Ages 16–20 Years	55.22%
Chlamydia Screening in Women—Ages 21–24 Years	66.17%
Chlamydia Screening in Women—Total	60.40%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	26.61%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	31.80%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.25%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.92%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.86%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	27.66%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	36.57%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	11.24%
Prenatal and Postpartum Care—Postpartum Care	88.56%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	97.32%

Table 3.4—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CenCal—Santa Barbara County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	61.79%
Cervical Cancer Screening	66.84%
Chlamydia Screening in Women—Ages 16–20 Years	51.08%
Chlamydia Screening in Women—Ages 21–24 Years	65.15%
Chlamydia Screening in Women—Total	57.59%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	17.64%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.10%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.40%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.89%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	7.22%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	40.51%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	36.08%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	15.38%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	11.22%
Prenatal and Postpartum Care—Postpartum Care	91.48%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	97.81%

Behavioral Health Domain

Table 3.5 and Table 3.6 present the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.5—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CenCal—San Luis Obispo County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	58.15%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	42.83%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	39.86%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	36.36%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	31.88%

Measure	Reporting Year 2020 Rate
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	32.73%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	23.97%

Table 3.6—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CenCal—Santa Barbara County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	54.37%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	38.45%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	43.39%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	55.56%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	35.65%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	28.83%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	19.08%

Acute and Chronic Disease Management Domain

Table 3.7 and Table 3.8 present the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.7—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
CenCal—San Luis Obispo County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	95.62%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	48.82
Asthma Medication Ratio—Total	67.53%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	28.64%
Comprehensive Diabetes Care—HbA1c Testing—Total	90.20%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.51%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	67.40%
HIV Viral Load Suppression—Ages 18–64 Years	S
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.05%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.76%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.93
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	5.45%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.8—Acute and Chronic Disease Management Domain Reporting Year 2020 Performance Measure Results CenCal—Santa Barbara County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	87.83%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	42.26
Asthma Medication Ratio—Total	64.72%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	23.94%
Comprehensive Diabetes Care—HbA1c Testing—Total	92.02%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.63%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	65.11%
HIV Viral Load Suppression—Ages 18–64 Years	S
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.97%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.54%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.94
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.86%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, CenCal will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.9 and Table 3.10 present the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.9—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CenCal—San Luis Obispo County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	86.75	46.64	Not Tested	48.82
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	96.28%	Not Comparable	96.28%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	91.23%	90.40%	0.83	90.41%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	84.76%	92.56%	-7.80	92.36%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	88.54%	91.38%	-2.84	91.29%
*Plan All-Cause Readmissions—Total***	11.35%	8.32%	3.03	9.05%

Table 3.10—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CenCal—Santa Barbara County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	85.08	40.35	Not Tested	42.26
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	96.95%	Not Comparable	96.97%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	94.15%	92.10%	2.05	92.12%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	94.70%	94.07%	0.63	94.08%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	93.12%	91.23%	1.89	91.27%
*Plan All-Cause Readmissions—Total***	12.15%	8.08%	4.07	8.97%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that CenCal stratified by the SPD and non-SPD populations and for which HSAG could make a comparison between the reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results in reporting year 2020:

- In San Luis Obispo County, members ages 7 to 11 years in the SPD population had significantly fewer visits with a primary care provider (PCP) during the measurement year than members in this age group in the non-SPD population. The significant differences may be attributed to members in the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from PCPs.

- In Santa Barbara County, the SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, CenCal submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, CenCal initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, CenCal identified completion of the human papillomavirus (HPV) vaccination among adolescents in Santa Barbara County as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure results reported by the MCP for its *HPV Vaccination* Disparity PIP.

Table 4.1—CenCal *HPV Vaccination* Disparity PIP SMART Aim Measure Results

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of members geographically located in South Santa Barbara County and assigned to Clinic A[6] who receive at least two HPV vaccinations by their 13th birthday	S	48.33%	No

[6] Clinic name removed for confidentiality.

Table 4.2 presents a description of the intervention that CenCal tested for its *HPV Vaccination* Disparity PIP. The table also indicates the key driver and failure mode that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—CenCal *HPV Vaccination* Disparity PIP Intervention Testing Results

Intervention	Key Driver and Failure Mode Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide interactive digital education via a tablet to all adolescent members' guardians in the waiting room/exam room about the importance of HPV immunization	♦ Lack of guardians' understanding of the importance of HPV immunization ♦ Provider clinic not presenting the importance of HPV immunization to the adolescent members' guardians at appointments	Continue Testing

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CenCal's *HPV Vaccination* Disparity PIP. In the modules, CenCal documented that it tested providing interactive education materials to adolescent members' guardians in the waiting room and exam room. The education materials were available via a tablet and encouraged parents/guardians to set up HPV immunization appointments for their adolescents. Despite CenCal's efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CenCal's *HPV Vaccination* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on CenCal's reporting year 2017 performance measure results, the MCP selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure results as reported by the MCP for its *Childhood Immunization Status—Combination 3* PIP.

Table 4.3—CenCal *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of *Childhood Immunization Status—Combination 3* measure at Provider A[7] in San Luis Obispo County	47.13%	65.25%	No

Table 4.4 presents a description of the intervention that CenCal tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the key driver and failure mode that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.4—CenCal *Childhood Immunization Status—Combination 3* PIP Intervention Testing Results

Intervention	Key Driver and Failure Mode Addressed	Adopt, Adapt, Abandon, or Continue Testing
Assist Provider A in expanding its scheduling system by identifying members assigned to Provider A who are due for one or more childhood immunizations and sending an electronic list of these members to Provider A. Provider A's call center agents contact members telephonically and track whether or not they attend their immunization appointments.	♦ Provider resources ♦ Pediatric members' parents/guardians not making appointments	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CenCal's *Childhood Immunization Status—Combination 3* PIP. In the modules, CenCal documented that it tested supporting a selected provider partner. Specifically, CenCal assisted the provider with its scheduling system by electronically sending lists of members under 2 years of age who are due for one or more immunizations. The provider partner's staff members contacted members' parents/guardians to schedule appointments and if necessary, rescheduled missed appointments. Despite CenCal's efforts, the MCP did not achieve the SMART Aim goal.

[7] Provider name removed for confidentiality.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CenCal's *Childhood Immunization Status—Combination 3* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, CenCal identified postpartum care for members residing in San Luis Obispo County as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 through 3 for the MCP's *Postpartum Care* Health Equity PIP. Upon initial review of the modules, HSAG determined that CenCal met some required validation criteria; however, HSAG identified opportunities for improvement related to including:

- All required components of the SMART Aim data collection methodology.
- A process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- All required components of the Intervention Plan.

After receiving technical assistance from HSAG, CenCal incorporated HSAG's feedback into modules 1 through 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 through 3.

Table 4.5 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the MCP's *Postpartum Care* Health Equity PIP.

Table 4.5—CenCal *Postpartum Care* Health Equity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of timely postpartum care following a live birth among members who reside in San Luis Obispo County	70.27%	77.29%

Table 4.6 presents a description of the intervention that CenCal selected to test for its *Postpartum Care* Health Equity PIP. The table also indicates the failure modes that the intervention aims to address.

Table 4.6—CenCal *Postpartum Care* Health Equity PIP Intervention Testing

Intervention	Failure Modes Addressed
MCP social workers conduct telephonic outreach calls to postpartum members residing in the city of San Luis Obispo	♦ Members do not contact the provider to schedule/reschedule postpartum visits ♦ Members do not know they need to schedule/reschedule postpartum visits

While CenCal advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, CenCal selected well-child visits in the first 15 months of life as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits in the First 15 Months of Life* PIP. Upon initial review of the modules, HSAG determined that CenCal met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.

After receiving technical assistance from HSAG, CenCal incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. CenCal was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, CenCal identified interventions that it can adapt and continue to test in efforts to improve immunizations among children and adolescents.

Opportunities for Improvement—Performance Improvement Projects

CenCal has the opportunity to monitor the continued and adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs. The MCP should apply lessons learned from these PIPs to facilitate improvement of the continued and adapted interventions and to strengthen future quality improvement efforts.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

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

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

CenCal submitted the MCP's PNA report to DHCS on June 26, 2020, and DHCS notified the MCP via email on July 7, 2020, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 7.1 provides EQR recommendations from CenCal's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of CenCal's self-reported actions.

Table 7.1—CenCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP fully resolves all findings from the November 2018 A&I Medical and State Supported Services Audits.	In May 2019, CenCal Health submitted corrective measures to address the 2018 A&I Medical Audit findings. In June 2020, CenCal Health received an audit closure letter stating that items have been reviewed and that DHCS accepted the plan's submitted CAP. The CAP is now closed.
2. Determine the causes for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate declining significantly from reporting year 2018 to reporting year 2019 in San Luis Obispo County and identify strategies to address the causes.	In 2018, San Luis Obispo County had 14 fires which affected members' ability to receive well care due to road closures and air quality concerns. Additionally, network provider coverage in San Luis Obispo County was limited due to many pediatric clinic locations being over capacity. CenCal Health put many interventions in place to address the decline in well-child visits. These included: ♦ Assisting network providers in recruitment activities for those pediatric clinic locations that were over capacity.

2018–19 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	Providing pediatricians with monthly gap-in-care reports including children who are due for well-child visits. The program commenced in October 2018.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CenCal's self-reported actions in Table 7.1 and determined that CenCal adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. CenCal indicated that the MCP took actions to fully resolve all findings from the 2018 A&I Medical Audit. Additionally, CenCal described the causes for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate declining significantly from reporting year 2018 to reporting year 2019 in San Luis Obispo County and interventions the MCP implemented to address the decline in well-child visits. Interventions included assisting network providers with recruiting additional providers and sending pediatricians monthly gap-in-care reports.

2019–20 Recommendations

Based on the overall assessment of CenCal's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Monitor the continued and adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs.
- Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the continued and adapted interventions and to strengthen future quality improvement efforts.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix K:
Performance Evaluation Report
Central California Alliance for Health
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Central California Alliance for Health ("CCAH" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in CCAH's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CCAH is a full-scope MCP delivering services to its members in the County Organized Health System model.

CCAH became operational to provide MCMC services in Santa Cruz County effective January 1996, in Monterey County effective October 1999, and Merced County effective October 2009. As of June 2020, CCAH had 123,594 members in Merced County, 155,950 in Monterey County, and 66,939 in Santa Cruz County—for a total of 346,483 members.[1]

DHCS allows CCAH to combine data for Monterey and Santa Cruz counties for reporting purposes. For this report, Monterey and Santa Cruz counties represent one single reporting unit, and Merced County represents another single reporting unit.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CCAH. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CCAH. A&I conducted the audits from November 4, 2019, through November 8, 2019. Note that the audits were limited-scope audits and did not include review of the Administrative and Organizational Capacity category.

**Table 2.1—DHCS A&I Medical and State Supported Services Audits of CCAH
Audit Review Period: November 1, 2018, through October 31, 2019**

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

Strengths—Compliance Reviews

A&I identified a finding in only one category (Member's Rights) during the November 2019 Medical and State Supported Services Audits of CCAH. Additionally, in response to the CAP from the November 2019 audits, CCAH submitted documentation to DHCS that resulted in DHCS closing the CAP. CCAH's documentation reflected changes the MCP implemented to

ensure that members are provided with fully translated grievance and appeal resolution letters in their identified threshold or concentration languages.

Opportunities for Improvement—Compliance Reviews

CCAH has no outstanding findings from the November 2019 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures CCAH chose to report using one or both of these two options.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of CCAH, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Central California Alliance for Health* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.8 for CCAH's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.8:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 and Table 3.2 present the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CCAH—Merced County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	55.23%
Childhood Immunization Status—Combination 10	19.71%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	95.33%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	89.16%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	91.01%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	90.78%

Measure	Reporting Year 2020 Rate
Developmental Screening in the First Three Years of Life—Total	10.38%
Immunizations for Adolescents—Combination 2	37.47%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	90.51%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	47.93%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.28%

Table 3.2—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CCAH—Monterey/Santa Cruz Counties

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	63.26%
Childhood Immunization Status—Combination 10	52.07%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	96.44%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	92.34%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	95.10%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	93.38%
Developmental Screening in the First Three Years of Life—Total	17.00%
Immunizations for Adolescents—Combination 2	60.73%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	90.51%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	63.99%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	86.46%

Women's Health Domain

Table 3.3 and Table 3.4 present the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.3—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CCAH—Merced County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	57.09%
Cervical Cancer Screening	62.77%
Chlamydia Screening in Women—Ages 16–20 Years	44.96%
Chlamydia Screening in Women—Ages 21–24 Years	63.22%
Chlamydia Screening in Women—Total	53.78%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.81%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	27.78%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.36%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.52%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	10.04%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	41.01%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	41.27%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	10.67%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	6.86%
Prenatal and Postpartum Care—Postpartum Care	79.56%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.27%

Table 3.4—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CCAH—Monterey/Santa Cruz Counties

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	60.88%
Cervical Cancer Screening	73.72%
Chlamydia Screening in Women—Ages 16–20 Years	59.13%
Chlamydia Screening in Women—Ages 21–24 Years	67.22%
Chlamydia Screening in Women—Total	62.53%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.01%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.50%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.84%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	7.13%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	9.29%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	12.29%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	46.84%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	46.75%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	8.18%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	5.02%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	26.77%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	19.50%
Prenatal and Postpartum Care—Postpartum Care	88.56%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.73%

Behavioral Health Domain

Table 3.5 and Table 3.6 present the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.5—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CCAH—Merced County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	51.66%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	33.20%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	48.07%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	46.15%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	2.93%

Measure	Reporting Year 2020 Rate
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	3.57%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	3.17%

Table 3.6—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CCAH—Monterey/Santa Cruz Counties

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	56.05%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	39.52%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	42.28%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	42.19%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	16.54%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	5.55%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	4.17%

Acute and Chronic Disease Management Domain

Table 3.7 and Table 3.8 present the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.7—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
CCAH—Merced County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	96.11%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	49.48
Asthma Medication Ratio—Total	66.34%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	37.23%
Comprehensive Diabetes Care—HbA1c Testing—Total	85.16%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	10.55%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	61.10%
HIV Viral Load Suppression—Ages 18–64 Years	NA
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	15.94%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.06%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.76
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.50%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.8—Acute and Chronic Disease Management Domain Reporting Year 2020 Performance Measure Results CCAH—Monterey/Santa Cruz Counties

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.24%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	45.77
Asthma Medication Ratio—Total	69.56%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	36.92%
Comprehensive Diabetes Care—HbA1c Testing—Total	89.24%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	12.11%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	62.76%
HIV Viral Load Suppression—Ages 18–64 Years	NA
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	18.58%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.26%
*Plan All-Cause Readmissions—O/E Ratio—Total***	2.01
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.04%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, CCAH will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.9 and Table 3.10 present the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.9—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CCAH—Merced County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	86.02	47.14	Not Tested	49.48
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	95.31%	Not Comparable	95.33%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	92.57%	89.09%	3.48	89.16%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	93.98%	90.91%	3.07	91.01%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	91.85%	90.74%	1.11	90.78%
*Plan All-Cause Readmissions—Total***	18.87%	14.69%	4.18	15.94%

Table 3.10—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CCAH—Monterey/Santa Cruz Counties

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	71.09	44.50	Not Tested	45.77
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	96.42%	Not Comparable	96.44%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	95.25%	92.30%	2.95	92.34%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	98.79%	95.01%	3.78	95.10%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	95.80%	93.32%	2.48	93.38%
*Plan All-Cause Readmissions—Total***	23.05%	17.38%	5.67	18.58%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that CCAH stratified by the SPD and non-SPD populations and for which HSAG could make a comparison between the reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results:

- The reporting year 2020 SPD rates were significantly better than the reporting year 2020 non-SPD rates for the following measures:
  - *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years* and *Ages 12–19 Years* in Monterey/Santa Cruz counties
  - *Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years* in both reporting units
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in both reporting units in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, CCAH submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, CCAH initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, CCAH identified opioid overdose deaths in Merced County as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure results reported by the MCP for its *Opioid Overdose Deaths* Disparity PIP.

Table 4.1—CCAH *Opioid Overdose Deaths* Disparity PIP SMART Aim Measure Results

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of naloxone (Narcan) fills among members on chronic opioids (opioid fills greater than 30 days within a rolling 12-month period, excluding those with a diagnosis of malignant neoplasm, end stage renal disease, human immunodeficiency virus, transplant, or end-of-life/palliative care) residing in Merced County	S	4.80%	Yes

Table 4.2 presents a description of the intervention that CCAH tested for its *Opioid Overdose Deaths* Disparity PIP. The table also indicates the key drivers and failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—CCAH *Opioid Overdose Deaths* Disparity PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
According to the tenets of academic detailing (NaRCAD), provide customized education and tools, collaboratively develop practice-change actions, and address identified barriers with providers in Merced County who serve the highest number of members on chronic opioids	♦ Appropriate identification of member opioid overdose risk ♦ Self-efficacy and intent/motivation of provider to both communicate the need and write a prescription for Narcan ♦ Provider did not communicate the need for Narcan ♦ Provider was not effective in communicating the need for Narcan	Continue Testing

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CCAH's *Opioid Overdose Deaths* Disparity PIP. CCAH documented in the modules that it tested academic detailing with eight providers in Merced County. For each provider, the MCP measured Narcan prescriptions filled by members who were on chronic opioids and provided a run chart that included an aggregate result for all providers in Merced County. The MCP reported that all providers except one improved beyond their baseline Narcan fill rates among members prescribed chronic opioids. CCAH determined to continue testing the intervention. The MCP exceeded the SMART Aim goal, with the highest rate achieved in June 2019.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CCAH's *Opioid Overdose Deaths* Disparity PIP a final confidence level of *Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on CCAH's reporting year 2017 performance measure results, the MCP selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure results as reported by the MCP for its *Childhood Immunization Status—Combination 3* PIP.

Table 4.3—CCAH *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of the *Childhood Immunization Status—Combination 3* measure for members assigned to Provider B[6]	32%	40%	No

Table 4.4 presents a description of the intervention that CCAH tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the key drivers and failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.4—CCAH *Childhood Immunization Status—Combination 3* PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide a monthly report to providers that identifies members who need or are past due for immunization services	♦ Identification of members who need (or are past due for) immunization services ♦ Parents/guardians do not know when vaccines are due and never call or walk into the clinic	Adopt

[6] Provider name removed for confidentiality.

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CCAH's *Childhood Immunization Status—Combination 3* PIP. In the modules, CCAH documented that it tested producing a list of members who need immunizations and conducted an outreach campaign using the list. The MCP tested the intervention from February 2019 to April 2019 and determined to adopt the intervention. Prior to testing generating the list of members who need immunizations, CCAH planned to test providing awareness and support for transportation services; however, because the MCP discovered that parents/guardians do not frequently use the transportation services, the MCP determined not to test the intervention. Despite CCAH's efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CCAH's *Childhood Immunization Status—Combination 3* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, CCAH identified adolescent well-care visits in Merced County as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Adolescent Well-Care Visits* Health Equity PIP. Upon initial review of the modules, HSAG determined that CCAH met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.
- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.

After receiving technical assistance from HSAG, CCAH incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. CCAH was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, CCAH determined to continue focusing on childhood immunizations for its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Childhood Immunization Status—Combination 10* PIP. Upon initial review of the modules, HSAG determined that CCAH met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.
- Including all required components of the SMART Aim run chart.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Labeling clearly the identified gaps or opportunities for improvement in the process map steps.

After receiving technical assistance from HSAG, CCAH incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. CCAH was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

CCAH achieved the SMART Aim goal for the 2017–19 *Opioid Overdose Deaths* Disparity PIP, and some of the quality improvement activities could be linked to the demonstrated improvement. Based on its assessment, HSAG assigned the 2017–19 *Opioid Overdose Deaths* Disparity PIP a final confidence level of *Confidence*. Upon completion of the 2017–19 *Childhood Immunization Status—Combination 3* PIP, CCAH identified interventions that it can adopt to improve immunization rates among children.

Opportunities for Improvement—Performance Improvement Projects

CCAH has the opportunity to continue testing the academic detailing intervention to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Opioid Overdose Deaths* Disparity PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine the intervention to achieve and sustain optimal outcomes. Additionally, CCAH has the opportunity to monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 3* PIP. Finally, the MCP should apply lessons learned from these PIPs to future quality improvement efforts.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

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

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

CCAH submitted the MCP's PNA report to DHCS on July 29, 2020, and DHCS notified the MCP via email on August 5, 2020, that DHCS approved the report as submitted. While CCAH submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Based on HSAG's assessment of CCAH's delivery of quality, accessible, and timely care through the activities described in the MCP's 2018–19 MCP-specific evaluation report, HSAG included no recommendations in CCAH's 2018–19 MCP-specific evaluation report. Therefore, CCAH had no recommendations for which it was required to provide the MCP's self-reported actions.

2019–20 Recommendations

Based on the overall assessment of CCAH's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Continue testing the academic detailing intervention to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Opioid Overdose Deaths* Disparity PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine the intervention to achieve and sustain optimal outcomes.
- Monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 3* PIP.
- Apply lessons learned from the 2017–19 PIPs to future quality improvement efforts.

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

Appendix L:
Performance Evaluation Report
Community Health Group
Partnership Plan
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Community Health Group Partnership Plan ("CHG" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in CHG's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CHG is a full-scope MCP delivering services to its members under a Geographic Managed Care (GMC) model. Although the GMC model operates in both San Diego and Sacramento counties, CHG only operates in San Diego County. In the GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county). In addition to CHG, San Diego County's beneficiaries may select from the following MCPs:

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

CHG became operational in San Diego County to provide MCMC services effective August 1998. As of June 2020, CHG had 251,383 members.[1] This represents 37 percent of the beneficiaries enrolled in San Diego County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CHG. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CHG. A&I conducted the audits from July 1, 2019, through July 3, 2019. The Medical Audit portion was a limited scope audit that included the Seniors and Persons with Disabilities (SPD) population.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CHG
Audit Review Period: June 1, 2018, through May 31, 2019

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

Strengths—Compliance Reviews

During the July 2019 Medical and State Supported Services Audits of CHG, A&I identified findings in only one category (Case Management and Coordination of Care). In response to the CAP from the July 2019 A&I Medical Audit, CHG submitted documentation to DHCS

related to the findings in the Case Management and Coordination of Care category. The closeout letter from DHCS dated March 11, 2020, included a description from CHG of the policy and procedure changes the MCP made to ensure subcontractors offer door-to-door services to members and to provide evidence to DHCS that the MCP uses the DHCS-approved Physician Certification Statement form to determine the appropriate levels of service for members.

Opportunities for Improvement—Compliance Reviews

CHG has no outstanding findings from the July 2019 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures CHG chose to report using one or both of these two options.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of CHG, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Community Health Group Partnership Plan* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for CHG's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CHG—San Diego County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	62.53%
Childhood Immunization Status—Combination 10	50.12%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	96.91%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	89.47%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	92.35%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	91.17%
Developmental Screening in the First Three Years of Life—Total	41.56%
Immunizations for Adolescents—Combination 2	48.66%

Measure	Reporting Year 2020 Rate
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	93.43%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	56.20%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.30%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CHG—San Diego County

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	69.36%
Cervical Cancer Screening	70.32%
Chlamydia Screening in Women—Ages 16–20 Years	66.06%
Chlamydia Screening in Women—Ages 21–24 Years	71.76%
Chlamydia Screening in Women—Total	68.64%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	16.42%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	27.83%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.04%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.51%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.82%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	36.49%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	36.98%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.96%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	20.38%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	12.49%
Prenatal and Postpartum Care—Postpartum Care	78.27%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.80%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CHG—San Diego County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	55.07%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	39.71%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	56.48%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	79.31%

Measure	Reporting Year 2020 Rate
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	30.85%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	23.60%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	20.22%

Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
CHG—San Diego County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	93.19%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	42.51
Asthma Medication Ratio—Total	65.45%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	25.30%
Comprehensive Diabetes Care—HbA1c Testing—Total	92.94%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	10.28%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	4.80%
Controlling High Blood Pressure—Total	72.26%

Measure	Reporting Year 2020 Rate
HIV Viral Load Suppression—Ages 18–64 Years	23.93%
HIV Viral Load Suppression—Ages 65+ Years	S
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.73%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.30%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.83
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	18.20%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	6.97%

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, CHG will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 SPD and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CHG—San Diego County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	69.27	40.59	Not Tested	42.51
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	96.89%	Not Comparable	96.91%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	96.75%	89.31%	7.44	89.47%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	96.91%	92.18%	4.73	92.35%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	94.88%	91.04%	3.84	91.17%
*Plan All-Cause Readmissions—Total***	10.15%	6.88%	3.27	7.73%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that CHG stratified by the SPD and non-SPD populations and for which HSAG could compare the reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results:

- The reporting year 2020 SPD rates were significantly better than the reporting year 2020 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years*, *Ages 7–11 Years*, and *Ages 12–19 Years* measures.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to CHG's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that CHG report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the reporting year 2020 rates for each required MLTSSP performance measure. Table 4.1 presents reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 4.1—Reporting Year 2020 MLTSSP Performance Measure Results
CHG—San Diego County

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	45.06
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.38%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.12%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.81

5. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, CHG submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, CHG initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, CHG identified annual provider visits among male members 20 to 30 years of age as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure results reported by the MCP for its *Annual Provider Visits* Disparity PIP.

Table 5.1—CHG *Annual Provider Visits* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of primary care visits among male members 20 to 30 years of age at Clinic A[6]	5.7%	10.0%	Yes

[6] Clinic name removed for confidentiality.

Table 5.2 presents a description of the intervention that CHG tested for its *Annual Provider Visits* Disparity PIP. The table also indicates the failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.2—CHG *Annual Provider Visits* Disparity PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Research and provide alternative member phone number(s) to providers	♦ Many phone numbers provided in the eligibility file are incorrect or not in service ♦ Incorrect phone numbers hinder establishing care with new members	Adopt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CHG's *Annual Provider Visits* Disparity PIP. In the modules, CHG documented that it tested researching alternative member phone numbers and providing the updated phone numbers to the clinic providers via the MCP's provider portal. The MCP trained the partner clinic on how to find the alternative member phone numbers on the provider portal to use the updated information for member outreach. Although CHG met the SMART Aim goal, the tested intervention could not be linked to the improvement.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CHG's *Annual Provider Visits* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on CHG's reporting year 2017 performance measure results, the MCP selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure results as reported by the MCP for its *Childhood Immunization Status—Combination 3* PIP.

Table 5.3—CHG *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of *Childhood Immunization Status—Combination 3* measure for Medical Group A[7]	67.1%	79.0%	No

Table 5.4 presents a description of the intervention that CHG tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.4—CHG *Childhood Immunization Status—Combination 3* PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Research and provide alternative member phone number(s) to providers	♦ Many phone numbers provided in the eligibility file are incorrect or not in service ♦ Incorrect phone numbers hinder establishing care with new members	Adopt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CHG's *Childhood Immunization Status—Combination 3* PIP. In the modules, CHG documented that it tested the same intervention as the *Annual Provider Visits* Disparity PIP, researched alternative member phone numbers, and provided the updated phone numbers to the medical group's providers via the MCP's provider portal. The MCP trained the partner medical group on how to find the alternative member phone numbers on the provider portal to use the updated information for member outreach. Despite CHG's efforts, the MCP did not achieve the SMART Aim goal.

[7] Medical group name removed for confidentiality.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CHG's *Childhood Immunization Status—Combination 3* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, CHG identified cervical cancer screening among members living in the cities of Lemon Grove, Spring Valley, and La Mesa as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Cervical Cancer Screening* Health Equity PIP. Upon initial review of the modules, HSAG determined that CHG met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- ♦ Including all required components of the SMART Aim data collection methodology.
- ♦ Including all required components of the SMART Aim run chart.
- ♦ Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- ♦ Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- ♦ Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.

After receiving technical assistance from HSAG, CHG incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. CHG was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, CHG selected adolescent well-care visits as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Adolescent Well-Care Visits* PIP. Upon initial review of the modules, HSAG determined that CHG met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.
- Including all required components of the SMART Aim run chart.
- Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Linking logically the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.
- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.

After receiving technical assistance from HSAG, CHG incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. CHG was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, CHG identified an intervention that it can adopt to ensure its providers have the most up-to-date member contact information so the providers can successfully contact members to schedule needed health care services.

Opportunities for Improvement—Performance Improvement Projects

CHG has the opportunity to monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2017–19 PIPs. The MCP should apply lessons learned from these PIPs to facilitate improvement of the adopted intervention and to strengthen future quality improvement efforts.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

CHG submitted the MCP's PNA report to DHCS on June 26, 2020, and DHCS notified the MCP via email on July 8, 2020, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Based on HSAG's assessment of CHG's delivery of quality, accessible, and timely care through the activities described in the MCP's 2018–19 MCP-specific evaluation report, HSAG included no recommendations in CHG's 2018–19 MCP-specific evaluation report. Therefore, CHG had no recommendations for which it was required to provide self-reported actions.

2019–20 Recommendations

Based on the overall assessment of CHG's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Monitor the adopted intervention to achieve optimal outcomes beyond the life of the 2017–19 PIPs.
- Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adopted intervention and to strengthen future quality improvement efforts.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix M:
Performance Evaluation Report
Contra Costa Health Plan
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Contra Costa Health Plan ("CCHP" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in CCHP's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

CCHP is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in CCHP, the Local Initiative MCP, or in Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, the alternative commercial plan.

CCHP became operational in Contra Costa County to provide MCMC services effective February 1997. As of June 2020, CCHP had 177,841 members.[1] This represents 87 percent of the beneficiaries enrolled in Contra Costa County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for CCHP. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of CCHP. A&I conducted the audits from April 8, 2019, through April 19, 2019.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of CCHP
Audit Review Period: June 1, 2018, through March 31, 2019

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

Follow-Up on 2018 A&I Medical Audit of CCHP

A&I conducted a Medical Audit of CCHP in June 2018, covering the review period of June 1, 2017, through May 31, 2018. HSAG provided a summary of the audit results and status in CCHP's 2018–19 MCP-specific evaluation report. At the time of the 2018–19 MCP-specific evaluation report publication, CCHP's CAP was in progress and under review by DHCS. A letter from DHCS dated June 25, 2020, stated that CCHP provided DHCS with additional information regarding the CAP, and that DHCS had reviewed the information and closed the CAP. The letter indicated that DHCS would monitor the MCP's full implementation of the CAP during the subsequent audit.

Strengths—Compliance Reviews

CCHP provided documentation to DHCS regarding changes the MCP made to its policies and procedures to ensure compliance with CCHP's DHCS contract. The documentation submitted by CCHP resulted in DHCS closing the CAP from the 2018 A&I Medical Audit of CCHP. Additionally, A&I identified no findings during the 2019 State Supported Services Audit.

Opportunities for Improvement—Compliance Reviews

During the 2019 Medical Audit, A&I identified findings in all six categories it evaluated and noted two repeat findings in the Member's Rights category. CCHP has the opportunity to work with DHCS to fully resolve all findings from the 2019 A&I Medical Audit, paying particular attention to the repeat findings in the Member's Rights category.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- ♦ Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- ♦ Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- ♦ Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures CCHP chose to report using one or both of these two options.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of CCHP, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Contra Costa Health Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that CCHP followed the appropriate specifications to produce valid rates; however, during primary source verification of a sample of randomly selected dual eligibility exclusions, the auditor noted that several members only had dual eligible coverage during part of the measurement year. The auditor indicated that to comply with NCQA's General Guideline 15 in which exclusions are to be applied according to the continuous enrollment requirements for each measure, CCHP should implement dual eligibility calculations in monthly enrollment spans.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for CCHP's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
CCHP—Contra Costa County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	47.93%
Childhood Immunization Status—Combination 10	51.34%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	95.79%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	88.94%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	90.47%

Measure	Reporting Year 2020 Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	88.21%
Developmental Screening in the First Three Years of Life—Total	24.38%
Immunizations for Adolescents—Combination 2	50.85%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	91.11%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	70.32%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	79.27%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
CCHP—Contra Costa County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	68.86%
Cervical Cancer Screening	68.37%
Chlamydia Screening in Women—Ages 16–20 Years	61.73%
Chlamydia Screening in Women—Ages 21–24 Years	76.63%
Chlamydia Screening in Women—Total	68.36%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	20.09%

Measure	Reporting Year 2020 Rate
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	27.98%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.76%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.09%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	15.79%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	18.01%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	57.89%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	46.56%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	4.65%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	33.68%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	19.34%
Prenatal and Postpartum Care—Postpartum Care	88.08%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.43%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
CCHP—Contra Costa County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	62.59%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	41.17%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	47.23%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	53.03%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	18.49%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	39.72%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	38.80%

Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
CCHP—Contra Costa County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	93.88%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	52.90
Asthma Medication Ratio—Total	60.48%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	37.71%
Comprehensive Diabetes Care—HbA1c Testing—Total	91.73%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	9.15%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	73.73%
HIV Viral Load Suppression—Ages 18–64 Years	80.05%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.26%
Plan All-Cause Readmissions—Expected Readmissions—Total	10.22%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.00
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.25%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, CCHP will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations CCHP—Contra Costa County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	82.63	49.69	Not Tested	52.90

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	95.82%	Not Comparable	95.79%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	91.67%	88.89%	2.78	88.94%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	94.35%	90.34%	4.01	90.47%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	89.73%	88.15%	1.58	88.21%
*Plan All-Cause Readmissions—Total***	12.80%	9.05%	3.75	10.26%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that CCHP stratified by the SPD and non-SPD populations and for which HSAG could compare reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results:

- The reporting year 2020 SPD rate was significantly better than the reporting year 2020 non-SPD rate for the *Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years* measure.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that CCHP followed the appropriate specifications to produce valid rates.

Opportunities for Improvement—Performance Measures

CCHP has the opportunity to update the MCP's enrollment determinations to monthly spans and implement dual eligibility calculations to ensure that dual eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, CCHP submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, CCHP initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

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

Table 4.1 provides the SMART Aim measure results reported by the MCP for its *Controlling Blood Pressure* Disparity PIP.

Table 4.1—CCHP *Controlling Blood Pressure* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of hypertension control among African-American members ages 18 to 85 who receive care at Clinic A[6]	61.40%	66.58%	No

[6] Clinic name removed for confidentiality.

Table 4.2 presents a description of the interventions that CCHP tested for its *Controlling Blood Pressure* Disparity PIP. The table also indicates the key drivers and failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—CCHP *Controlling Blood Pressure* Disparity PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Pilot a reminder call program for African-American members who are overdue for primary care provider (PCP) appointments	♦ Engaging members who have not been seen for routine care ♦ No routine follow-up done on members who are overdue for, miss, or cancel appointments	Abandon
Conduct nurse home visits to African-American members with uncontrolled hypertension to provide blood pressure management education and an Omron blood pressure cuff for checking their own blood pressure	♦ Social and environmental factors that impact blood pressure control	Continue Testing

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CCHP's *Controlling Blood Pressure* Disparity PIP. In the modules, CCHP documented that it tested the outreach call intervention from January 2019 through March 2019. The MCP determined that the intervention required a significant amount of resources yet only yielded a low rate of successful contacts with members; therefore, the MCP abandoned the outreach intervention. In the modules, CCHP documented that it tested the nurse home visit intervention in May 2019 and June 2019. Based on initial results, the MCP determined that the nurse home visits were successful, and the MCP indicated that it will continue to test the intervention beyond the life of the PIP. Despite CCHP's efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CCHP's *Controlling Blood Pressure* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on CCHP's reporting year 2017 performance measure results, the MCP selected nephropathy screening among members living with diabetes as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure results as reported by the MCP for its *Diabetes Nephropathy Screening* PIP.

Table 4.3—CCHP *Diabetes Nephropathy Screening* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of nephropathy screening among members ages 18 to 75 with a diagnosis of diabetes who reside in Contra Costa County and receive care at Health Center A[7]	77.78%	91.97%	No

Table 4.4 presents a description of the intervention that CCHP tested for its *Diabetes Nephropathy Screening* PIP. The table also indicates the key driver that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.4—CCHP *Diabetes Nephropathy Screening* PIP Intervention Testing Results

Intervention	Key Driver Addressed	Adopt, Adapt, Abandon, or Continue Testing
Conduct provider trainings to educate providers on the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure specification and various ways to meet measure compliance	Lack of providers' knowledge regarding what constitutes compliance for nephropathy screening and treatment	Adapt

[7] Health center name removed for confidentiality.

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for CCHP's *Diabetes Nephropathy Screening* PIP. CCHP planned to test offering an in-home nephropathy screening as well as emailing PCPs a list of members who are overdue for nephropathy screening; however, the MCP encountered numerous roadblocks which prevented it from testing the two interventions. Instead, CCHP documented that it tested the provider training intervention in May 2019 and June 2019. The MCP educated providers on ways to meet compliance for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure in order to increase the measure rate. The MCP determined the provider trainings were well-received and determined to adapt the intervention. Despite CCHP's efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned CCHP's *Diabetes Nephropathy Screening* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, CCHP identified improving diabetes control among members who identify as Hispanic/Latino and speak Spanish as their primary language as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Diabetes Control* Health Equity PIP. Upon initial review of the modules, HSAG determined that CCHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the:
  - SMART Aim.
  - SMART Aim data collection methodology.
  - SMART Aim run chart.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Labeling clearly the identified gaps or opportunities for improvement in the process map steps.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.

After receiving technical assistance from HSAG, CCHP incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. CCHP was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, CCHP selected well-child visits in the first 15 months of life as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 through 3 for the MCP's *Well-Child Visits in the First 15 Months of Life* PIP. Upon initial review of the modules, HSAG determined that CCHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.
- Including all required components of the SMART Aim run chart.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Labeling clearly the identified gaps or opportunities for improvement in the process map steps.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.
- Including at least one key driver and failure mode in the Intervention Plan.
- Including all required components of the Intervention Plan.
- Ensuring that the intervention effectiveness measure was appropriate for the intervention.

After receiving technical assistance from HSAG, CCHP incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. CCHP received the initial Module 3 validation findings when DHCS determined to end the 2019–21 PIPs; therefore, the MCP did not have an opportunity to incorporate HSAG's feedback into Module 3.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, CCHP identified an intervention that it can continue to test to improve blood pressure control among its African-American members. Additionally, the MCP identified an intervention that it can adapt to increase nephropathy screening among its members living with diabetes.

Opportunities for Improvement—Performance Improvement Projects

CCHP has the opportunity to monitor the continued and adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs. The MCP should apply lessons learned from these PIPs to facilitate improvement of the continued and adapted interventions and to strengthen future quality improvement efforts.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

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

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

CCHP submitted the MCP's PNA report to DHCS on July 20, 2020, and DHCS notified the MCP via email on August 5, 2020, that DHCS approved the report as submitted. While CCHP submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 7.1 provides EQR recommendations from CCHP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of CCHP's self-reported actions.

Table 7.1—CCHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP fully resolves all findings from the June 2018 A&I Medical and State Supported Services Audits	CCHP worked with DHCS compliance staff members to address evidence to show CCHP verifies the identity, licensure, and background of licensed staff members to ensure that care to members is not compromised. CCHP also worked to address the concern that only appropriate practitioners make clinical decisions. We standardized both our nurse and physician interrater reliability processes and took steps to ensure that updated criteria are used and discussed at clinical meetings. We adopted NCQA's Quality Compass as a standard for comparing inpatient, outpatient, and emergency room services under- and overutilization, in addition to participating in a chief medical officer workgroup. CCHP continues to monitor delegated utilization management functions, requires quarterly utilization management reporting, and conducts annual audits. We have worked on making our Notice of Action letters clear and concise for a sixth-grade reading level. We have implemented internal auditing processes

2018–19 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	and are improving turnaround-time processing. In other areas such as quality management, we are improving our initial health assessment monitoring and provider education. For member services, we are ensuring that quality of care cases are investigated, adjudicated, and properly categorized. We have worked to educate our providers so that they know how to forward grievances and have the proper forms. For claims, we have implemented checks to ensure that we reimburse non-contracted emergency room and family planning providers at no less than the Medi-Cal fee-for-service rate. For case management, we have implemented minor consent forms for both non-medical transportation and non-emergency medical transportation, and updated our policy and procedure for health risk assessments. For Health Insurance Portability and Accountability Act of 1996 and fraud, waste, and abuse reporting, we have worked with DHCS to update our policies to include a new tracking log for privacy cases to ensure timely reporting to all listed recipients.

Assessment of MCP's Self-Reported Actions

HSAG reviewed CCHP's self-reported actions in Table 7.1 and determined that CCHP adequately addressed HSAG's recommendation from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. CCHP described in detail policies and procedures it has implemented to ensure the MCP is compliant with DHCS contract requirements and to fully resolve all findings from the June 2018 A&I Medical and State Supported Services Audits.

2019–20 Recommendations

Based on the overall assessment of CCHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- ♦ Work with DHCS to fully resolve all findings from the 2019 A&I Medical Audit, paying particular attention to the repeat findings in the Member's Rights category.
- ♦ Update the MCP's enrollment determinations to monthly spans and implement dual eligibility calculations to ensure that dual eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.
- ♦ Monitor the continued and adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs.
- ♦ Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the continued and adapted interventions and to strengthen future quality improvement efforts.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix N:
Performance Evaluation Report
Family Mosaic Project
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted SHP, Family Mosaic Project ("FMP" or "the SHP"). The purpose of this appendix is to provide SHP-specific results of each activity and an assessment of the SHP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this SHP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in FMP's 2020–21 SHP-specific evaluation report. This SHP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Specialty Health Plan Overview

FMP is an SHP which provides intensive case management and wraparound services for MCMC children and adolescents at risk of out-of-home placement in San Francisco County. FMP is part of the Child, Youth, and Family System of Care operated by the City and County of San Francisco Department of Public Health (SFDPH) Community Behavioral Health Services. To receive services from FMP, a beneficiary must meet specific enrollment criteria, including being a San Francisco resident between 3 and 18 years of age, having serious mental health care needs, and being at imminent risk of (or already in) out-of-home placement. FMP submits qualifying clients to DHCS for approval to be enrolled in FMP's MCMC. Once a client is approved and included under FMP's contract with DHCS, The SHP receives a per-member, per-month capitated rate to provide mental health and related wraparound services. Due to FMP's unique membership, some SHP contract requirements differ from the MCP contract requirements.

FMP became operational in San Francisco County to provide MCMC services effective December 1992. As of June 2020, FMP's number of members was too small to report based on the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

DHCS' Audits & Investigation Division (A&I) conducts triennial oversight reviews of specialty mental health services provided by each county mental health plan (MHP) to determine compliance with federal and State regulations as well as with the terms of the MHP contract. DHCS works closely with each MHP to ensure compliance and to identify opportunities for improvement. Using a collaborative and educational approach, DHCS provides guidance and technical assistance when it determines that the MHP is out of compliance. After the review, DHCS provides feedback related to areas of non-compliance. DHCS provides the MHP with a written report of findings which includes a description of each finding and a description of any corrective actions needed. Within 60 days of receiving the final report of findings, MHPs are required to submit to DHCS a corrective action plan (CAP) for all items that DHCS determined to be out of compliance. If an urgent issue is identified, the issue is addressed immediately.

DHCS did not conduct an oversight review of FMP directly during the review period for this report. The most recent review conducted by DHCS was a triennial on-site review of the San Francisco County MHP from April 24, 2017, through April 27, 2017. FMP is part of the Children, Youth, & Family System of Care operated by the San Francisco Department of Public Health Community Behavioral Health Services; therefore, FMP was included in the April 24, 2017, review. HSAG included a summary of the April 2017 review in FMP's 2016–17 SHP-specific evaluation report.

3. Specialty Health Plan Performance Measures

Performance Measure Validation Results

For reporting year 2020, FMP was required to report two performance measures—*Promotion of Positive Pro-Social Activity* and *School Attendance*. Neither measure is a Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measure; therefore, HSAG conducted performance measure validation (PMV) for the two performance measures selected, calculated, and reported by the SHP. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services' (CMS') publication, *EQR Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019.[3]

The *2020 Validation of Performance Measures Final Report of Findings for Family Mosaic Project* contains the detailed findings and recommendations from HSAG's PMV of the two measures that FMP reported. The HSAG auditor determined that FMP followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results

After validating FMP's performance measure rates, HSAG assessed the results. See Table 3.1 for FMP's performance measure results for reporting years 2018, 2019, and 2020. The reporting year is the year in which the SHP reported the rates. The reporting year rates reflect measurement year data from the previous calendar year. Note that FMP had less than 30 beneficiaries during all three reporting years depicted in Table 3.1, resulting in an "NA" audit designation for each performance measure.

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

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 27, 2020.

Table 3.1—Multi-Year Performance Measure Results
FMP—San Francisco County

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

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

Reporting year 2020 rates reflect measurement data from January 1, 2019, through December 31, 2019.

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

Not Comparable = A reporting year 2019–20 rate difference cannot be made because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Reporting Year 2018 Rate	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
School Attendance	NA	NA	NA	Not Comparable
Promotion of Positive Pro-Social Activity	NA	NA	NA	Not Comparable

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on performance measure results, HSAG identified no opportunities for improvement for FMP in the area of performance measures.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, FMP submitted final modules for its two 2017–19 SHP-specific PIPs. HSAG provided final validation findings and encouraged the SHP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, FMP initiated the 2019–21 SHP-specific PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the SHP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Reducing Physical Health Issues Performance Improvement Project

FMP selected reduction of physical health issues as one of its 2017–19 PIP topics based on its SHP-specific data.

Table 4.1 provides the SMART Aim measure results reported by the SHP for its *Reducing Physical Health Issues* PIP.

Table 4.1—FMP *Reducing Physical Health Issues* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of members ages 0 to 18 years who score 0 or 1 on the Physical/Medical rating, which evaluates members' health problems and chronic/acute conditions	83%	90%	No

Table 4.2 presents a description of the intervention that FMP tested for its *Reducing Physical Health Issues* PIP. The table also indicates the key drivers that the intervention addressed and whether the SHP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—FMP *Reducing Physical Health Issues* PIP Intervention Testing Results

Intervention	Key Drivers Addressed	Adopt, Adapt, Abandon, or Continue Testing
Have a psychiatrist provide psychoeducation to members with physical health concerns and serve as a liaison between members and the primary care providers (PCPs)	♦ Identification of members who have significant health issues ♦ Members' and caregivers' initial access/linkage to health care resources (clinics, providers, and treatment) for physical health issues	Abandon

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for FMP's *Reducing Physical Health Issues* PIP. In the modules, FMP documented that it tested the impact of having the SHP's psychiatrist conduct psychoeducation about the relationship between physical health and mental health and serve as a liaison between the members and the members' PCPs. While the SHP tested the intervention as planned, FMP learned that the intervention did not result in any members significantly improving their Physical/Medical rating, and the SHP did not achieve the SMART Aim goal. The SHP documented that the original plan was to have the nurse practitioner conduct the intervention; however, due to staffing changes, the psychiatrist conducted the intervention. FMP indicated that due to the nurse practitioner's role to engage families, provide psychoeducation, and when needed, conduct home visits to reduce barriers to engagement, having the nurse practitioner implement the intervention would have been a better fit. Additionally, FMP indicated that the physical health challenges the members faced were more extensive to address than expected. FMP determined to abandon the intervention as the SHP currently does not have the appropriate staff member to coordinate the challenging physical health needs of members.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned FMP's *Reducing Physical Health Issues* PIP a final confidence level of *Low Confidence*.

2017–19 Improving Client Access and Use of Recreational Activities Performance Improvement Project

FMP selected improving client access to and use of recreational activities as its other 2017–19 PIP topic based on its SHP-specific data.

Table 4.3 provides the SMART Aim measure results as reported by the SHP for its *Improving Client Access and Use of Recreational Activities* PIP.

Table 4.3—FMP *Improving Client Access and Use of Recreational Activities* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of members ages 0 to 18 years who score 0 or 1 on the Recreational rating, which reflects members' access to and use of leisure time activities	50%	70%	No

Table 4.4 presents a description of the intervention that FMP tested for its *Improving Client Access and Use of Recreational Activities* PIP. The table also indicates the key drivers that the intervention addressed and whether the SHP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.4—FMP *Improving Client Access and Use of Recreational Activities* PIP Intervention Testing Results

Intervention	Key Drivers Addressed	Adopt, Adapt, Abandon, or Continue Testing
Have a staff member of the behavioral support team accompany members to the first three sessions of a recreational activity	♦ Identification of members who have limited access to or engagement in recreational activities ♦ Members' and caregivers' initial identification/linkage to potential recreational activities for members	Abandon

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for FMP's *Improving Client Access and Use of Recreational Activities* PIP. In the modules, FMP documented that it tested having an SHP staff member accompany members to their first three recreational activity sessions to increase the members' attendance at the sessions. Although the SHP made every effort to reduce the barriers for members to attend the sessions, the families' expectations regarding how the members should be spending their out-of-school time resulted in none of the members attending all three sessions, and the SHP did not achieve the SMART Aim goal. FMP learned that when developing this type of intervention in the future, the SHP needs to consider that members may have other priorities, such as being the sole caretaker of their younger siblings, that may interfere with their ability to attend the recreational activity sessions.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned FMP's *Improving Client Access and Use of Recreational Activities* PIP a final confidence level of *Low Confidence*.

2019–21 Reducing Anxiety Symptoms Performance Improvement Project

FMP selected reducing anxiety symptoms as its first 2019–21 PIP topic based on its SHP-specific data.

During the review period of this report, HSAG validated Module 1 for the SHP's *Reducing Anxiety Symptoms* Health Equity PIP. Upon initial review of the module, HSAG determined that FMP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of:
  - The SMART Aim statement.
  - The SMART Aim data collection methodology.
  - The SMART Aim run chart.
- Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.

After receiving technical assistance from HSAG, FMP incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the SHP met all validation criteria for Module 1. FMP was in the process of working on its Module 2 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Improving Family Functioning Performance Improvement Project

FMP selected improving family functioning as its second 2019–21 PIP topic based on its SHP-specific data.

During the review period for this report, HSAG validated Module 1 for the SHP's *Improving Family Functioning* PIP. Upon initial review of the module, HSAG determined that FMP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of:
  - The SMART Aim statement.
  - The SMART Aim data collection methodology.
  - The SMART Aim run chart.
- Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.

After receiving technical assistance from HSAG, FMP incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the SHP met all validation criteria for Module 1. FMP was in the process of working on its Module 2 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, FMP identified lessons learned that it can apply to strengthen future quality improvement efforts.

Opportunities for Improvement—Performance Improvement Projects

FMP has the opportunity to apply the lessons learned from the 2017–19 PIPs to facilitate improvement for future PIPs.

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Based on HSAG's assessment of FMP's delivery of quality, accessible, and timely care through the activities described in the SHP's 2018–19 SHP-specific evaluation report, HSAG included no recommendations in FMP's 2018–19 SHP-specific evaluation report. Therefore, FMP had no recommendations for which it was required to provide the SHP's self-reported actions.

2019–20 Recommendations

Based on the overall assessment of FMP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that FMP apply the lessons learned from the 2017–19 PIPs to facilitate improvement for future PIPs.

In the next annual review, the EQRO will evaluate continued successes of FMP as well as the SHP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix O:
Performance Evaluation Report
Gold Coast Health Plan
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Gold Coast Health Plan ("GCHP" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in GCHP's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

GCHP is a full-scope MCP delivering services to its members in the County Organized Health System model.

GCHP became operational to provide MCMC services in Ventura County effective July 2011. As of June 2020, GCHP had 199,742 members.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for GCHP. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of GCHP. A&I conducted the audits from June 3, 2019, through June 7, 2019. In addition to evaluating the seven categories included in Table 2.1, A&I assessed GCHP's implementation and effectiveness of the MCP's CAP from the previous year's audits.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of GCHP Audit Review Period: April 1, 2018, through March 31, 2019

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

Strengths—Compliance Reviews

A&I identified a finding in only one category (Member's Rights) during the June 2019 Medical and State Supported Services Audits of GCHP. DHCS indicated in a CAP closeout letter dated February 19, 2020, that on January 3, 2020, GCHP submitted additional information to DHCS regarding the CAP, resulting in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

GCHP has no outstanding findings from the June 2019 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures GCHP chose to report using one or both of these two options.

[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of GCHP, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Gold Coast Health Plan* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for GCHP's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
GCHP—Ventura County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	58.15%
Childhood Immunization Status—Combination 10	42.09%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	95.49%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	87.63%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	89.76%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	86.83%

Measure	Reporting Year 2020 Rate
Developmental Screening in the First Three Years of Life—Total	32.43%
Immunizations for Adolescents—Combination 2	37.96%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	94.89%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	54.99%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.59%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
GCHP—Ventura County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	61.84%
Cervical Cancer Screening	64.23%
Chlamydia Screening in Women—Ages 16–20 Years	48.84%
Chlamydia Screening in Women—Ages 21–24 Years	64.87%
Chlamydia Screening in Women—Total	56.02%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.55%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	29.65%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	4.01%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.94%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.02%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	45.51%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	43.34%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.55%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	25.75%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	17.90%
Prenatal and Postpartum Care—Postpartum Care	86.86%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	97.32%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
GCHP—Ventura County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	63.18%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	46.78%

Measure	Reporting Year 2020 Rate
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	32.73%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	33.75%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	1.64%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	1.00%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	1.65%

Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
GCHP—Ventura County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	93.19%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	43.85
Asthma Medication Ratio—Total	50.09%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	32.85%

Measure	Reporting Year 2020 Rate
Comprehensive Diabetes Care—HbA1c Testing—Total	89.29%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.29%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	63.26%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.43%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.03%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.93
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.70%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, GCHP will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations GCHP—Ventura County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	73.92	42.32	Not Tested	43.85
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	95.49%	Not Comparable	95.49%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	86.59%	87.66%	-1.07	87.63%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	91.16%	89.72%	1.44	89.76%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	86.96%	86.82%	0.14	86.83%
*Plan All-Cause Readmissions— Total***	10.28%	7.96%	2.32	8.43%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that GCHP stratified by the SPD and non-SPD populations and for which HSAG could make a comparison between the reporting year 2020 SPD rate and reporting year 2020 non-SPD rate, GCHP had no statistically significant differences between the SPD and non-SPD rates.

Strengths—Performance Measures

The HSAG auditor determined that GCHP followed the appropriate specifications to produce valid rates.

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, GCHP submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, GCHP initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, GCHP identified poor control of diabetes (defined as an HbA1c level above 9 percent) among non-English-speaking Hispanic/Latino members as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure results reported by the MCP for its *Diabetes Poor HbA1c Control* Disparity PIP.

Table 4.1—GCHP *Diabetes Poor HbA1c Control* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of poor blood glucose levels (HbA1c >9.0 percent) among non-English-speaking Hispanic/Latino members living with diabetes, 18 to 75 years of age, who are enrolled at Provider Group A[6]	70.39%	59.20%	No

[6] Provider group name removed for confidentiality.

Table 4.2 presents a description of the intervention that GCHP tested for its *Diabetes Poor HbA1c Control* Disparity PIP. The table also indicates the key drivers that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—GCHP *Diabetes Poor HbA1c Control* Disparity PIP Intervention Testing Results

Intervention	Key Drivers Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide Provider Group A with a monthly report of members who have had no HbA1c test completed so the clinic can outreach to members to provide point-of-care HbA1c tests and diabetes education	♦ Clinic unable to reach members ♦ Language barriers ♦ Cultural barriers ♦ Data management and reporting ♦ Lack of member knowledge on how to manage diabetes ♦ Members are non-compliant with treatment plans and doctor's orders	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for GCHP's *Diabetes Poor HbA1c Control* PIP. In the modules that it tested, GCHP documented collaborating with a provider partner to send monthly reports of members who were due for HbA1c tests so that the provider partner could conduct telephonic member outreach to schedule HbA1c testing appointments. The MCP tested the intervention from September 2018 through June 2019. While GCHP determined that the intervention was successful in improving members' awareness of the need to complete HbA1c tests to control their diabetes, the MCP identified challenges to conducting effective and consistent outreach due to staffing shortages and lack of diabetes-focused outreach training. The MCP decided to adapt the intervention to target other populations. Despite GCHP's efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned GCHP's *Diabetes Poor HbA1c Control* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on GCHP's reporting year 2017 performance measure results, the MCP selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure results as reported by the MCP for its *Childhood Immunization Status—Combination 3* PIP.

Table 4.3—GCHP *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of *Childhood Immunization Status—Combination 3* measure for Provider Group B[7]	73.64%	83.64%	No

Table 4.4 presents a description of the interventions that GCHP tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the key drivers and failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.4—GCHP *Childhood Immunization Status—Combination 3* PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Implement a coordinated MCP/clinic telephonic outreach program to schedule child immunization appointments	♦ No clinic staff are assigned to conduct outreach ♦ Educate parents/guardians on the importance of child immunizations ♦ Inform parents/guardians which child immunizations are incomplete	Abandon

[7] Provider group name removed for confidentiality.

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
	♦ Schedule immunization appointments	
Implement a process for the clinic to assess the immunization status of all members less than 2 years of age who have a clinic visit with Provider Group B	♦ MCP does not always have the most up-to-date claims/encounter and supplemental data to produce the most up-to-date gap reports for outreach ♦ No clinic staff are assigned to conduct outreach ♦ Clinic assesses immunization status only during well-child exam ♦ Parents/guardians unaware of which vaccines are needed or have been completed	Adopt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for GCHP's *Childhood Immunization Status—Combination 3* PIP. GCHP documented in the modules that it tested two interventions. The MCP abandoned the telephonic outreach intervention due to challenges with generating a reliable outreach report and establishing an efficient appointment scheduling process. Instead, GCHP tested a process for the provider partner to assess the immunization status of 2-year-old members who had a clinic visit. The provider partner found the process to be a successful enhancement to the clinic's workflow and that it led to an improved coordination of care for members; thus, the MCP chose to adopt this intervention. Despite GCHP's efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned GCHP's *Childhood Immunization Status—Combination 3* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS

encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, GCHP identified cervical cancer screening in Area 5 (which includes Oxnard and Port Hueneme) as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Cervical Cancer Screening* Health Equity PIP. Upon initial review of the modules, HSAG determined that GCHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.

After receiving technical assistance from HSAG, GCHP incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. GCHP was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, GCHP selected adolescent well-care visits as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 through 3 for the MCP's *Adolescent Well-Care Visits* PIP. Upon initial review of the modules, HSAG determined that GCHP met all modules 1 and 2 validation criteria in its initial submission; however, HSAG identified opportunities for improvement related to including all required components of the Intervention Plan in Module 3. GCHP received the initial Module 3 validation findings when DHCS determined to end the 2019–21 PIPs; therefore, the MCP did not have an opportunity to incorporate HSAG's feedback into Module 3.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, GCHP identified an intervention that it can adapt to improve member awareness of the importance of completing HbA1c tests to control diabetes. The MCP also identified a successful process for provider office staff members to assess

members' immunization status that can be adopted by other providers to improve immunization compliance among young children.

Opportunities for Improvement—Performance Improvement Projects

GCHP has the opportunity to monitor the adopted and adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs. The MCP should apply lessons learned from these PIPs to facilitate improvement of the interventions and to strengthen future quality improvement efforts.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

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

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

GCHP submitted its PNA report to DHCS on June 30, 2020, and DHCS notified the MCP via email on July 22, 2020, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

7. Recommendations

Follow-Up on Prior Year Recommendations

Each year, DHCS provides each MCP, PSP, and the SHP an opportunity to outline actions taken to address the EQRO recommendations from the previous year. Based on HSAG's assessment of GCHP's delivery of quality, accessible, and timely care through the activities described in the MCP's 2018–19 MCP-specific evaluation report, HSAG had no prior year recommendations requiring GCHP follow-up in this report.

2019–20 Recommendations

Based on the overall assessment of GCHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Monitor the adopted and adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs.
- Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the interventions and to strengthen future quality improvement efforts.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix P:
Performance Evaluation Report
Health Net Community Solutions, Inc.
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Health Net Community Solutions, Inc. ("Health Net" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in Health Net's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

Health Net is a full-scope MCP delivering services to its members as a commercial MCP under the Two-Plan Model and also under a Geographic Managed Care (GMC) model.

Health Net became operational in Sacramento County to provide MCMC services in 1994 and then expanded to additional contracted counties, the most recent being San Joaquin County, effective January 2013.

Health Net's Two-Plan Model

Table 1.1 shows the counties in which Health Net provided services to its members under the Two-Plan Model and denotes which MCP is the "Local Initiative." Beneficiaries may enroll in Health Net, the commercial MCP; or in the alternative Local Initiative.

Table 1.1—Local Initiative Plans under the Two-Plan Model in Counties in which Health Net Serves as the Commercial Managed Care Health Plan

County	Local Initiative Plan
Kern	Kern Health Systems, DBA Kern Family Health Care
Los Angeles	L.A. Care Health Plan
San Joaquin	Health Plan of San Joaquin
Stanislaus	Health Plan of San Joaquin
Tulare	Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan

Health Net's Geographic Managed Care Model

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

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

- Aetna Better Health of California
- Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
- Kaiser NorCal
- Molina Healthcare of California

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

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

Health Net's Enrollment

Table 1.2 shows the counties in which Health Net provides MCMC services, Health Net's enrollment for each county, the MCP's total number of members, and the percentage of beneficiaries in the county enrolled in Health Net as of June 2020.[1]

Table 1.2—Health Net Enrollment as of June 2020

County	Enrollment as of June 2020	Percentage of Beneficiaries in the County Enrolled in Health Net
Kern	64,560	19%
Los Angeles	932,570	31%
Sacramento	107,196	25%
San Diego	65,865	10%
San Joaquin	19,518	8%
Stanislaus	60,431	31%
Tulare	110,464	53%
Total	**1,360,604**	

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Health Net. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Health Net. A&I conducted the audits from May 21, 2019, through May 31, 2019.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Health Net Audit Review Period: May 1, 2018, through April 30, 2019

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

Follow-Up on 2018 A&I Medical Audit of Health Net

A&I conducted a Medical Audit of Health Net in 2018, covering the review period of May 1, 2017, through April 30, 2018. HSAG provided a summary of the audit results and status in Health Net's 2018–19 MCP-specific evaluation report. At the time of the 2018–19 MCP-specific evaluation report publication, Health Net's CAP was in progress and under review by DHCS. A letter from DHCS dated July 23, 2019, stated that Health Net provided DHCS with additional information regarding the CAP, and that DHCS had reviewed the information and closed the CAP. The letter indicated that DHCS would monitor the MCP's full implementation of the CAP during the subsequent audit.

Strengths—Compliance Reviews

Following the 2018 and 2019 A&I Medical Audits of Health Net, the MCP provided documentation to DHCS regarding changes the MCP made to its policies and procedures to ensure compliance with Health Net's DHCS contract. The documentation submitted by Health Net resulted in DHCS closing the CAPs from the 2018 and 2019 A&I Medical Audits. Additionally, A&I identified no findings in the Utilization Management and State Supported Services categories during the 2019 Medical and State Supported Services Audits of Health Net.

Opportunities for Improvement—Compliance Reviews

Health Net has no outstanding findings from the 2018 and 2019 A&I Medical Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures Health Net chose to report using one or both of these two options.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of Health Net, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Health Net Community Solutions, Inc.* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that Health Net followed the appropriate specifications to produce valid rates; however, during primary source verification of a sample of randomly selected dual eligibility exclusions, the auditor noted that several members only had dual eligible coverage during part of the measurement year. The auditor indicated that to comply with NCQA's General Guideline 15 in which exclusions are to be applied according to the continuous enrollment requirements for each measure, Health Net should implement dual eligibility calculations in monthly enrollment spans.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.28 for Health Net's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.28:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 through Table 3.7 present the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Kern County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	41.12%
Childhood Immunization Status—Combination 10	26.03%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	90.14%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	81.11%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	80.17%

Measure	Reporting Year 2020 Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	80.11%
Developmental Screening in the First Three Years of Life—Total	55.09%
Immunizations for Adolescents—Combination 2	35.52%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	72.99%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	50.12%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.21%

Table 3.2—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Los Angeles County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	50.36%
Childhood Immunization Status—Combination 10	27.98%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	91.90%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	82.24%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	86.00%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	83.31%
Developmental Screening in the First Three Years of Life—Total	45.01%
Immunizations for Adolescents—Combination 2	41.36%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	87.10%

Measure	Reporting Year 2020 Rate
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	53.77%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.43%

Table 3.3—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Sacramento County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	51.82%
Childhood Immunization Status—Combination 10	32.36%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	93.06%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	84.61%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	82.97%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	81.30%
Developmental Screening in the First Three Years of Life—Total	54.50%
Immunizations for Adolescents—Combination 2	41.61%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	86.86%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	53.04%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.01%

Table 3.4—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—San Diego County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	49.39%
Childhood Immunization Status—Combination 10	38.93%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	92.04%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	82.38%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	86.74%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	84.04%
Developmental Screening in the First Three Years of Life—Total	58.60%
Immunizations for Adolescents—Combination 2	36.50%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	86.37%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	55.87%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.56%

Table 3.5—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—San Joaquin County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	39.17%
Childhood Immunization Status—Combination 10	36.23%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	92.02%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	76.92%

Measure	Reporting Year 2020 Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	74.19%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	74.53%
Developmental Screening in the First Three Years of Life—Total	12.76%
Immunizations for Adolescents—Combination 2	31.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	85.89%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	50.78%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	62.53%

Table 3.6—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Stanislaus County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	45.01%
Childhood Immunization Status—Combination 10	27.98%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	88.26%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	79.59%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	81.97%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	80.06%
Developmental Screening in the First Three Years of Life—Total	35.09%
Immunizations for Adolescents—Combination 2	27.74%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	82.97%

Measure	Reporting Year 2020 Rate
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	49.39%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.07%

Table 3.7—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Tulare County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	64.96%
Childhood Immunization Status—Combination 10	40.88%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	97.31%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	92.45%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	92.82%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	91.33%
Developmental Screening in the First Three Years of Life—Total	27.43%
Immunizations for Adolescents—Combination 2	43.55%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	87.59%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	65.94%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.11%

Assessment of Corrective Action Plan—Children's Health Domain

In April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Health Net conducted as part of its CAP prior to April 2020.

Based on reporting year 2019 performance measure results, the following two measures within the Children's Health domain were included in Health Net's CAP:

- *Childhood Immunization Status—Combination 3* in Kern, Sacramento, San Diego, San Joaquin, and Stanislaus counties
  - Note that DHCS required MCPs to report rates for the *Childhood Immunization Status—Combination 10* measure in reporting year 2020 in place of the *Childhood Immunization Status—Combination 3* measure; therefore, Health Net's CAP quality improvement activities focused on the *Childhood Immunization Status—Combination 10* measure.
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in San Joaquin County

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of Health Net's performance related to the two measures within the Children's Health domain for which the MCP conducted PDSA cycles or a PIP.

Childhood Immunizations

To address Health Net's performance below the minimum performance level for the *Childhood Immunization Status—Combination 10* measure in Kern, Sacramento, San Diego, San Joaquin, and Stanislaus counties, DHCS approved the MCP to conduct a *Childhood Immunizations—Combination 10* PIP in place of conducting PDSA cycles. HSAG includes a summary of Health Net's progress on the *Childhood Immunizations—Combination 10* PIP in Section 5 of this report ("Performance Improvement Projects").

Well-Child Visits

DHCS approved Health Net to conduct PDSA cycles to address the MCP's performance below the minimum performance level for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in San Joaquin County.

Health Net tested whether conducting follow-up telephone outreach calls a second time to parents of members who were non-compliant with their well-child visits would result in the members completing their well-child visits. The follow-up outreach calls targeted parents who were previously included in reminder outreach calls and who did not follow through with having their children complete a well-child visit. To reduce the barrier of parents not prioritizing completion of well-child visits, the MCP provided education on the importance of these visits and conducted the outreach calls using three-way calling so that the well-child appointments could be scheduled immediately. Health Net reported that almost 40 percent of the targeted parents had their children complete a well-child visit by the time the MCP made the second outreach call, which exceeded the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objective goal of 20 percent. Based on the intervention's success, Health Net determined that it would be helpful to add the follow-up outreach calls to the member outreach intervention in 2020.

Women's Health Domain

Results—Women's Health Domain

Table 3.8 through Table 3.14 present the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.8—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Kern County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	53.25%
Cervical Cancer Screening	54.01%
Chlamydia Screening in Women—Ages 16–20 Years	42.11%
Chlamydia Screening in Women—Ages 21–24 Years	56.48%
Chlamydia Screening in Women—Total	49.36%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	14.18%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	22.09%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.21%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.62%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	5.91%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	34.83%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	32.72%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	13.48%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	8.13%
Prenatal and Postpartum Care—Postpartum Care	67.64%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.56%

Table 3.9—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Los Angeles County

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	62.13%
Cervical Cancer Screening	61.06%
Chlamydia Screening in Women—Ages 16–20 Years	66.10%
Chlamydia Screening in Women—Ages 21–24 Years	71.78%
Chlamydia Screening in Women—Total	68.86%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	11.30%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	21.10%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	1.59%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.58%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	2.46%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	10.10%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	26.88%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	29.89%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	1.59%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	2.02%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	7.37%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	7.58%
Prenatal and Postpartum Care—Postpartum Care	66.91%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.13%

Table 3.10—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Sacramento County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	56.04%
Cervical Cancer Screening	51.09%
Chlamydia Screening in Women—Ages 16–20 Years	69.97%
Chlamydia Screening in Women—Ages 21–24 Years	67.73%
Chlamydia Screening in Women—Total	68.97%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	14.66%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	20.68%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.51%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.88%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	5.43%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	35.06%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	28.32%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	7.86%
Prenatal and Postpartum Care—Postpartum Care	77.86%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.48%

Table 3.11—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—San Diego County

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

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	55.08%
Cervical Cancer Screening	51.82%
Chlamydia Screening in Women—Ages 16–20 Years	58.23%
Chlamydia Screening in Women—Ages 21–24 Years	64.50%
Chlamydia Screening in Women—Total	60.42%

Measure	Reporting Year 2020 Rate
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	17.34%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	22.26%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.31%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.88%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.52%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	33.48%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	10.43%
Prenatal and Postpartum Care—Postpartum Care	75.72%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	86.59%

Table 3.12—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—San Joaquin County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	47.77%
Cervical Cancer Screening	49.39%
Chlamydia Screening in Women—Ages 16–20 Years	60.19%
Chlamydia Screening in Women—Ages 21–24 Years	66.95%
Chlamydia Screening in Women—Total	63.74%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	14.72%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	21.45%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	S
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.92%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	25.45%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	S
Prenatal and Postpartum Care—Postpartum Care	67.98%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.83%

Table 3.13—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Stanislaus County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	58.82%
Cervical Cancer Screening	54.26%
Chlamydia Screening in Women—Ages 16–20 Years	47.92%
Chlamydia Screening in Women—Ages 21–24 Years	67.86%
Chlamydia Screening in Women—Total	56.29%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.22%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.60%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.17%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	11.67%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	41.94%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.80%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	19.35%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	7.98%
Prenatal and Postpartum Care—Postpartum Care	80.54%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.89%

Table 3.14—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Tulare County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	56.70%
Cervical Cancer Screening	68.04%
Chlamydia Screening in Women—Ages 16–20 Years	52.06%
Chlamydia Screening in Women—Ages 21–24 Years	65.47%
Chlamydia Screening in Women—Total	58.48%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.41%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	31.39%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.15%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.34%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.41%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	49.40%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	48.34%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	17.26%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	12.14%
Prenatal and Postpartum Care—Postpartum Care	88.08%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	94.40%

Assessment of Corrective Action Plan—Women's Health Domain

As previously stated, in April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Health Net conducted as part of its CAP prior to April 2020.

Based on reporting year 2019 performance measure results, the following two measures within the Women's Health domain were included in Health Net's CAP:

- *Breast Cancer Screening—Total* in San Diego and San Joaquin counties
- *Prenatal and Postpartum Care—Postpartum Care* in Los Angeles County

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of Health Net's performance related to the two measures within the Women's Health domain for which the MCP conducted PDSA cycles or submitted a Pilot Quality Improvement Strategy Summary/Progress report.

Breast Cancer Screening

DHCS approved Health Net to conduct PDSA cycles to address the MCP's performance below the minimum performance level for the *Breast Cancer Screening—Total* measure in San Diego and San Joaquin counties.

Health Net tested whether conducting in-home visits with members in San Joaquin County who had not completed their breast cancer screenings would result in the members getting screened. The MCP's Member Connections Team provided education and encouragement to members and offered to schedule appointments for the members while conducting the in-home visits. When identifying members for the in-home visits, Health Net included members who also had not yet completed their cervical cancer screening or their blood pressure or HbA1c testing. The MCP indicated that members were not as engaged as anticipated and that they declined assistance with scheduling appointments, stating that they would schedule the screenings themselves. To address some of the barriers encountered when testing the intervention (e.g., gated communities), Health Net reported learning that moving forward, it is important to provide the Member Connections Team with more detailed information about the members' addresses and common themes noted in the gap-in-care data prior to the in-home visits.

Postpartum Care

The rate for the *Prenatal and Postpartum Care—Postpartum Care* measure was below the minimum performance level in reporting year 2019 in Los Angeles County. DHCS approved Health Net to submit a Pilot Quality Improvement Strategy Summary/Progress report, which described the quality improvement strategies the MCP implemented to improve its performance on the measure. Health Net reported that it continued to implement a member outreach intervention that it began in October 2018 to increase the number of members who schedule a timely postpartum visit. The MCP conducted the outreach via phone and home visits. The MCP's Member Retention Team made three phone call attempts to reach members, and the Member Connections Team conducted unannounced home visits to members who recently delivered a baby and could not be reached by the Member Retention Team via phone. During the home visits, the Member Connections Team member conducted a postpartum mood and anxiety disorder assessment, made referrals to needed resources, and scheduled the postpartum appointment to occur within the recommended time frame. Health Net reported that in calendar year 2019, 79 percent of the members the Member Connections Team contacted self-reported that they had already completed or scheduled their postpartum visit.

In addition to the member outreach intervention, the MCP reported that it continued to create and distribute a postpartum care best practice protocol to provider offices, conduct internal training on the new technical specifications, and work with the largest provider group to improve administrative postpartum rates.

Behavioral Health Domain

Table 3.15 through Table 3.21 present the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.15—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Kern County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	50.56%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	34.64%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	21.70%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.60%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Table 3.16—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Los Angeles County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	51.74%

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	36.55%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	26.85%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	29.35%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	10.64%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	6.90%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	7.56%

Table 3.17—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Sacramento County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	52.21%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	36.92%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	26.87%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	33.33%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.26%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.70%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	1.78%

Table 3.18—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—San Diego County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	57.49%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	41.71%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	33.77%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	S
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	10.84%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	13.20%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	12.38%

Table 3.19—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—San Joaquin County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	54.86%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	38.19%

Measure	Reporting Year 2020 Rate
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	S
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.00%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.26%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%

Table 3.20—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Stanislaus County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	52.38%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	32.38%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	35.71%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	35.56%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	S
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Table 3.21—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Health Net—Tulare County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	43.18%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	27.48%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	41.38%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	51.47%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.79%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.32%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.22 through Table 3.28 present the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.22—Acute and Chronic Disease Management Domain Reporting Year 2020 Performance Measure Results Health Net—Kern County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	90.51%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	46.03
Asthma Medication Ratio—Total	50.64%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	35.77%
Comprehensive Diabetes Care—HbA1c Testing—Total	87.35%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	20.64%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	59.12%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.32%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.24%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.01
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.61%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.23—Acute and Chronic Disease Management Domain Reporting Year 2020 Performance Measure Results Health Net—Los Angeles County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.73%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	41.11
Asthma Medication Ratio—Total	59.07%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	33.58%
Comprehensive Diabetes Care—HbA1c Testing—Total	89.78%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	13.90%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	13.91%
Controlling High Blood Pressure—Total	63.52%
HIV Viral Load Suppression—Ages 18–64 Years	2.50%
HIV Viral Load Suppression—Ages 65+ Years	S
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.36%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.20%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.02
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.61%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S

Table 3.24—Acute and Chronic Disease Management Domain Reporting Year 2020 Performance Measure Results Health Net—Sacramento County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.73%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	50.52
Asthma Medication Ratio—Total	62.10%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	36.50%
Comprehensive Diabetes Care—HbA1c Testing—Total	84.18%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	9.77%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	54.26%
HIV Viral Load Suppression—Ages 18–64 Years	9.52%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.59%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.89%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.17
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	8.75%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.25—Acute and Chronic Disease Management Domain Reporting Year 2020 Performance Measure Results Health Net—San Diego County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	92.21%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	37.23
Asthma Medication Ratio—Total	68.45%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	32.03%
Comprehensive Diabetes Care—HbA1c Testing—Total	89.24%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.66%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	20.00%
Controlling High Blood Pressure—Total	66.84%
HIV Viral Load Suppression—Ages 18–64 Years	S
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.55%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.46%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.12
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	9.88%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S

Table 3.26—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Health Net—San Joaquin County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	93.43%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	46.76
Asthma Medication Ratio—Total	61.29%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	38.20%
Comprehensive Diabetes Care—HbA1c Testing—Total	84.67%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	10.50%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	64.09%
HIV Viral Load Suppression—Ages 18–64 Years	S
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.76%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.51%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.03
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	7.64%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.27—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Health Net—Stanislaus County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member’s “contribution” to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.00%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	50.98
Asthma Medication Ratio—Total	62.45%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	37.23%
Comprehensive Diabetes Care—HbA1c Testing—Total	86.13%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.15%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	63.50%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.20%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.49%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.08
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	5.57%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.28—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Health Net—Tulare County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	96.11%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	36.43
Asthma Medication Ratio—Total	69.55%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	36.01%
Comprehensive Diabetes Care—HbA1c Testing—Total	93.19%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	14.22%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	64.07%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.12%
Plan All-Cause Readmissions—Expected Readmissions—Total	8.89%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.91
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	1.97%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Assessment of Corrective Action Plan—Acute and Chronic Disease Management Domain

As previously stated, in April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Health Net conducted as part of its CAP prior to April 2020.

Based on reporting year 2019 performance measure results, the following two measures within the Acute and Chronic Disease Management domain were included in Health Net's CAP:

- *Asthma Medication Ratio—Total* in Kern County
- *Comprehensive Diabetes Care—HbA1c Testing—Total* in San Joaquin County

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of Health Net's performance related to the two measures within the Acute and Chronic Disease Management domain for which the MCP conducted PDSA cycles.

Asthma Medication Ratio

DHCS approved Health Net to conduct PDSA cycles to improve the MCP's performance on the *Asthma Medication Ratio—Total* measure in Kern County. The MCP planned to test whether using a text messaging campaign to provide education to members about the importance of their asthma controller medications and a referral to the MCP's Member Services Team for assistance with filling their prescriptions would result in more members filling or refiling their asthma controller medication prescriptions. Due to delays in DHCS providing approval of the texting vendor and text messages and the effects of COVID-19, the MCP had to place this intervention on hold.

Comprehensive Diabetes Care—HbA1c Testing

DHCS approved Health Net to conduct PDSA cycles to improve the MCP's performance on the *Comprehensive Diabetes Care—HbA1c Testing—Total* measure in San Joaquin County. Health Net began testing a member outreach intervention in partnership with a clinic in San Joaquin County to determine if the intervention would result in members scheduling and completing their HbA1c testing. Due to staffing shortages at the clinic, Health Net was unable to complete the data collection for the intervention. The MCP reported that the members who received the outreach education from the clinic were receptive to the information. Additionally, the MCP indicated learning that for future PDSA cycle activities, it will need to provide more information to clinic partners about what is needed from the clinic partners for successful completion of the intervention testing.

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the “Reporting Year 2020 Quality Monitoring and Corrective Action Plans” heading in this section, Health Net will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP’s strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Note that in September 2020, DHCS notified Health Net that DHCS was closing the MCP’s CAP, which was based on DHCS’ previous performance measure set (External Accountability Set). To ensure continued monitoring of Health Net’s performance, DHCS will require Health Net to meet quarterly via telephone with the MCP’s assigned DHCS nurse consultant. While DHCS notified Health Net of the CAP closure outside the review period for the MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.29 through Table 3.35 present the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.29—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—Kern County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit’s total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	83.22	42.62	Not Tested	46.03
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	90.15%	Not Comparable	90.14%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	89.71%	80.92%	8.79	81.11%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	80.08%	80.17%	-0.09	80.17%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	81.48%	80.06%	1.42	80.11%
*Plan All-Cause Readmissions—Total***	11.99%	7.95%	4.04	9.32%

Table 3.30—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—Los Angeles County

[green] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

[red] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	62.83	39.35	Not Tested	41.11
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	91.43%	91.90%	-0.47	91.90%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	86.85%	82.13%	4.72	82.24%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	87.73%	85.93%	1.80	86.00%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	83.68%	83.29%	0.39	83.31%
*Plan All-Cause Readmissions—Total***	12.53%	8.36%	4.17	9.36%

Table 3.31—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—Sacramento County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	84.95	46.70	Not Tested	50.52
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	93.11%	Not Comparable	93.06%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	87.88%	84.53%	3.35	84.61%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	86.50%	82.83%	3.67	82.97%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	82.23%	81.26%	0.97	81.30%
*Plan All-Cause Readmissions—Total***	13.29%	10.24%	3.05	11.59%

Table 3.32—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—San Diego County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	58.80	35.55	Not Tested	37.23

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	92.11%	Not Comparable	92.04%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	83.45%	82.35%	1.10	82.38%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	82.35%	86.91%	-4.56	86.74%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	77.72%	84.30%	-6.58	84.04%
*Plan All-Cause Readmissions—Total***	13.94%	9.29%	4.65	10.55%

Table 3.33—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—San Joaquin County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	86.79	43.94	Not Tested	46.76
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	92.02%	Not Comparable	92.02%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	82.86%	76.79%	6.07	76.92%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	80.00%	74.05%	5.95	74.19%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	68.75%	74.76%	-6.01	74.53%
*Plan All-Cause Readmissions—Total***	NA	8.81%	Not Comparable	9.76%

Table 3.34—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—Stanislaus County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	80.99	48.53	Not Tested	50.98
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	88.20%	Not Comparable	88.26%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	89.08%	79.39%	9.69	79.59%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	88.37%	81.73%	6.64	81.97%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	83.89%	79.89%	4.00	80.06%
*Plan All-Cause Readmissions—Total***	11.87%	9.44%	2.43	10.20%

Table 3.35—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Health Net—Tulare County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	63.03	34.82	Not Tested	36.43
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	97.29%	Not Comparable	97.31%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	93.22%	92.43%	0.79	92.45%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	94.53%	92.76%	1.77	92.82%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	94.37%	91.20%	3.17	91.33%
*Plan All-Cause Readmissions—Total***	12.77%	6.52%	6.25	8.12%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that Health Net stratified by the SPD and non-SPD populations and for which HSAG could compare reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results:

- The reporting year 2020 SPD rates were significantly better than the reporting year 2020 non-SPD rates for the following measures:
  - *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years* in Kern, Los Angeles, and Stanislaus counties
  - *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* in Los Angeles and Stanislaus counties
  - *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* in Stanislaus and Tulare counties
- In San Diego County, members ages 7 to11 years and 12 to 19 years in the SPD population had significantly fewer instances of a visit with a primary care provider (PCP) during the measurement year than members in these age groups in the non-SPD population in reporting year 2020. The significant differences may be attributed to members ages 7 to 19 in the SPD population in San Diego County choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from PCPs.
- The SPD population in Kern, Los Angeles, Sacramento, and Tulare counties had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that Health Net followed the appropriate specifications to produce valid rates.

Opportunities for Improvement—Performance Measures

Health Net has the opportunity to update the MCP's enrollment determinations to monthly spans and implement dual eligibility calculations to ensure that dual eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Health Net's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Health Net report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 and Table 4.2 present the reporting year 2020 rates for each required MLTSSP performance measure. Table 4.1 and Table 4.2 present reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 4.1—Reporting Year 2020 MLTSSP Performance Measure Results Health Net—Los Angeles County

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	78.68
*Plan All-Cause Readmissions—Observed Readmissions—Total***	13.91%
Plan All-Cause Readmissions—Expected Readmissions—Total	11.46%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.21

Table 4.2—Reporting Year 2020 MLTSSP Performance Measure Results
Health Net—San Diego County

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

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	56.19
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA
Plan All-Cause Readmissions—Expected Readmissions—Total	NA
*Plan All-Cause Readmissions—O/E Ratio—Total***	NA

5. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, Health Net submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, Health Net initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, Health Net identified cervical cancer screening among Mandarin-speaking Chinese members as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure results reported by the MCP for its *Cervical Cancer Screening* Disparity PIP.

Table 5.1—Health Net *Cervical Cancer Screening* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of cervical cancer screening among Chinese members ages 24 to 64 assigned to Provider Group A[6] whose preferred language is English or Mandarin.	56.1%	62.0%	Yes

[6] Provider group name removed for confidentiality.

Table 5.2 presents a description of the interventions that Health Net tested for its *Cervical Cancer Screening* Disparity PIP. The table also indicates the failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.2—Health Net *Cervical Cancer Screening* Disparity PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Write a prescription for cervical cancer screening (in English and Chinese/Mandarin) for women to schedule an appointment for their cervical cancer screening	♦ Cervical cancer screening is not a priority among Chinese women ♦ Appointment availability for cervical cancer screening ♦ Limited or no education about preventive screening for Chinese members in the provider's office	Adapt
Provide an on-site member incentive at provider partner sites for cervical cancer screening completion	♦ Members must schedule another appointment with another provider other than their PCP to complete a cervical cancer screening	Abandon

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Health Net's *Cervical Cancer Screening* Disparity PIP. In the modules, Health Net documented that it tested two interventions. One of the interventions was to prescribe members to schedule an appointment for their cervical cancer screening. The MCP tested the intervention at two different locations from January 2019 through June 2019. While some women who received the prescription from one of the locations ultimately completed their cervical cancer screening, no one from the other location followed through with getting the screening. Thus, Health Net decided to adapt the intervention at the location that had some success. In March 2019, Health Net began to test an on-site point-of-service member incentive for cervical cancer screening completion. The MCP decided to abandon the intervention due to no member completing the screening by the end of April 2019. Based on the SMART AIM measure data Health Net documented in its modules, the MCP met the SMART Aim goal in March 2019; however, the improvement could not clearly be linked to either of the interventions tested.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned Health Net's *Cervical Cancer Screening* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on Health Net's reporting year 2017 performance measure results, the MCP selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure results as reported by the MCP for its *Childhood Immunization Status—Combination 3* PIP.

Table 5.3—Health Net *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate for the *Childhood Immunization Status—Combination 3* measure among members who reside in Kern County and are assigned to Provider Group C[7]	58.76%	66.18%	No

Table 5.4 presents a description of the intervention that Health Net tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the key driver and failure mode that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.4—Health Net *Childhood Immunization Status—Combination 3* PIP Intervention Testing Results

Intervention	Key Driver and Failure Mode Addressed	Adopt, Adapt, Abandon, or Continue Testing
Offer a two-part immunization incentive to members for being up to date at age 1 and for completing the vaccination series by age 2	♦ Member engagement ♦ Parents only value and keep certain appointments	Adapt

[7] Provider group name removed for confidentiality.

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Health Net's *Childhood Immunization Status—Combination 3* PIP. In the modules, Health Net documented that it tested a two-part incentive intervention, providing the first gift card for members who were up to date with their immunizations at 12 months of age and the second gift card for completing the *Childhood Immunization Status—Combination 3* series prior to their second birthday. The MCP indicated testing the incentive intervention from October 2018 through June 2019 and identified numerous challenges with obtaining intervention effectiveness measure data from the provider partner. Due to the lack of accurate data from the provider partner, Health Net was unable to conclude if the two-part incentive intervention impacted the SMART Aim. Additionally, the MCP did not achieve the SMART Aim goal for the PIP.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned Health Net's *Childhood Immunization Status—Combination 3* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, Health Net identified cervical cancer screening among members living in Sacramento County as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Cervical Cancer Screening* Health Equity PIP. Health Net met all validation criteria for modules 1 and 2 in its initial submission. The MCP was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, Health Net selected childhood immunizations as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Childhood Immunization Status—Combination 10* PIP. Health Net met all validation criteria for

modules 1 and 2 in its initial submission. The MCP was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, Health Net identified interventions that it can adapt to improve member compliance for cervical cancer screening and childhood immunizations.

Opportunities for Improvement—Performance Improvement Projects

Health Net has the opportunity to monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs. The MCP should apply lessons learned from these PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 (“Validation of Network Adequacy”) provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS’ process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

Health Net submitted the MCP's PNA report to DHCS on June 30, 2020, and DHCS notified the MCP via email on July 24, 2020, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from Health Net's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of Health Net's self-reported actions.

Table 8.1—Health Net's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP fully resolves all findings from the 2018 Medical and State Supported Services Audits.	Health Net worked with DHCS to resolve the 2018 Medical and State Supported Services audit findings. The CAP addressing the findings was submitted on December 18, 2018, and the audit was closed on July 23, 2019.
2. For the following measures with rates below the minimum performance levels in reporting year 2019, determine which quality improvement strategies contributed to improvement from reporting year 2018 to reporting year 2019 and expand these successful strategies within the MCP, across counties, and in new provider sites, as applicable:	
♦ *Asthma Medication Ratio* in Kern County (The rate for this measure was also below the minimum performance level in reporting year 2018 for this reporting unit.)	***Asthma Medication Ratio*** ♦ In Q3 and Q4 2019, as well as Q1 and Q2 2020, a texting outreach program in Kern County was completed with members who were non-adherent with their asthma controller medication refills based on the HEDIS *Asthma Medication Ratio* measure specification. Text message lessons include education on the different types of asthma medications (controller and rescue medications), reinforcement on the importance of medication adherence, and encouragement to fill their asthma medication prescriptions. The program pilot concluded March 20, 2020. The results will be

2018–19 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	analyzed and shared as part of the PDSA process. Pharmacy outreach calls will be going out to members with asthma in the asthma care improvement program. ♦ In Q2 2020, Sacramento, San Joaquin, Stanislaus, and Los Angeles counties were added to the asthma text messaging program. The asthma text messaging campaign was a PDSA for Kern County. Despite the PDSA's cancellation by DHCS due to COVID-19, Health Net is continuing the implementation of the text messaging campaign, which is expected to launch in five Health Net counties in August 2020.
♦ *Breast Cancer Screening* in San Diego and San Joaquin counties (The rates for this measure were also below the minimum performance level in reporting year 2018 for both reporting units.)	***Breast Cancer Screening*** ♦ In Q3 and Q4 2019, members with breast cancer screening care gaps were included in the Member Connections in-home visit outreach for the following counties: Sacramento, Stanislaus, San Joaquin, Los Angeles, Kern, and Tulare. Members received a $25 point-of-care incentive for attending one of the Health Net-partnered mobile mammography events (standalone events and through the one-stop clinic model). Members were also eligible for an incentive for care received through a scheduled visit with a doctor for a mammogram. The Susan G. Komen Pilot Partnership held nine events in Q3 2019, resulting in 93 members being screened. In Q4 2019, four events were held, resulting in 59 members being screened. The mobile mammography program held 18 events in Q3, resulting in 280 members being screened. In Q4 2019, nine events were held, resulting in 92 members being screened. Members who completed their breast cancer screening received a $25 point-of-care incentive. ♦ The HEDIS team performed outreach calls to non-compliant members from San Joaquin, Sacramento, Kern, Stanislaus, and San Diego

2018–19 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	counties to offer the member incentive and provide scheduling assistance. ♦ The first San Joaquin County *Breast Cancer Screening* measure PDSA report was submitted in mid-October 2019. The MCP is reporting on breast cancer screening outreach conducted through a clinic partnership via the Member Connections Team. ♦ The Health Education Department provided assistance with appointment scheduling to help non-compliant members understand the importance of preventive health services (immunizations, diabetes screenings, well-child visits, and breast and cervical cancer screenings) and schedule the members to attend a one-stop, point-of-care, or community health-screening event. ♦ The Member Connections Team completed 21 in-home visits with women needing a breast cancer screening, including educating these women on the importance of preventive services. As a result, three members scheduled appointments. ♦ The Susan G. Komen Pilot Partnership resulted in six events in Q1 2020, resulting in 34 members being screened. These were the final events for this program. It will not be continuing in 2020. ♦ The mobile mammography program continues, holding events for members across the regions. In Q1 2020, we limited scheduling events to reevaluate the effectiveness of the mobile mammography program. One event was held in Q1 2020, resulting in 20 members being screened. ♦ In Q1 and Q2 2020, Health Net offered incentives for non-compliant members (all Health Net counties) for closing gaps in care. This continued deployment of the Medi-Cal Member Reward Cards Program is the main program in 2020 that Health Net will use to incentivize members to follow through with getting needed health care

2018–19 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	services. There is a multichannel outreach approach to non-compliant members to reward completion of individually defined health care activities. The planned deployment was Q1 2020 but was postponed due to delays in the approval process with DHCS. ♦ Due to COVID-19, the PDSA for the *Breast Cancer Screening* measure in partnership with Member Connections did not continue into another cycle. ♦ Health Net will continue its collaboration with providers and radiology centers that offer mammography to ensure completed member mammography data are sent to Health Net. ♦ The Health Education Department created a partnership with "Every Woman Counts" to provide monthly virtual classes on breast and cervical cancer screening for 2020.
♦ *Childhood Immunization Status—Combination 3* in Kern, Sacramento, San Diego, San Joaquin, and Stanislaus counties (The rates for this measure have been below the minimum performance levels for more than three consecutive years in Kern, Sacramento, San Joaquin, and Stanislaus counties.)	***Childhood Immunization Status—Combination 3*** ♦ In Q3 and Q4 2019, Health Net implemented a $50 point-of-care and member incentive mailing for timely *Childhood Immunization Status—Combination 10* series completion. Health Net also introduced the monthly *Childhood Immunization Status* flu series outreach to parents of members ages 6 to 23 months who had not completed the *Childhood Immunization Status* flu series. ♦ The HEDIS team completed outreach to non-compliant members in San Joaquin, Sacramento, Kern, and Stanislaus counties to offer the member incentive and provide scheduling assistance to members who were turning 2 years old in the next two months. ♦ The Health Education Department completed phone education and appointment scheduling to help non-compliant members understand the importance of preventive health services (immunizations, diabetes screenings, well-child visits, and breast and cervical cancer screenings)

<table>
<tr><th>2018–19 External Quality Review Recommendations Directed to Health Net</th><th>Self-Reported Actions Taken by Health Net during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations</th></tr>
<tr><td></td><td>
and schedule them to attend a one-stop, point-of care, or community health-screening event.

In Q1 and Q2 2020, Health Net completed process mapping and a failure modes and effects analysis for the Childhood Immunization Status—Combination 10 PIP with a provider in Kern County.
Health Net engaged providers to participate in one-stop events to close gaps. This program was deployed to additional providers in Kern County in Q2 2020.
<table>
<tr><th>County</th><th>One-Stop Events</th><th>Members Seen</th></tr>
<tr><td>Kern</td><td>4</td><td>65</td></tr>
<tr><td>Tulare</td><td>1</td><td>21</td></tr>
</table>

Health Net collaborated with a high-volume federally qualified health center (FQHC) in Kern County on the Childhood Immunization Status—Combination 10 PIP. Despite cancellation of the PIPs as of June 30, 2020, the continuation of the work with the FQHC to improve the Childhood Immunization Status—Combination 10 measure rate is pending the FQHC's approval.
Health Net completed a process map, failure modes and effects analysis, and key driver diagram (Module 2) for the Childhood Immunization Status—Combination 10 PIP.
Health Net distributed rewards to members who had services completed in 2019 through Q2 2020. This program ended June 30, 2020.The planned launch for 2020 Medi-Cal Member Reward Cards is Q3 2020, pending DHCS approval for this program.

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<table>
<tr><th>2018–19 External Quality Review Recommendations Directed to Health Net</th><th>Self-Reported Actions Taken by Health Net during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations</th></tr>
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♦ *Comprehensive Diabetes Care—HbA1c Testing* in San Joaquin County (The rates for this measure have been below the minimum performance levels for more than three consecutive years in this reporting unit.)

</td><td>

Comprehensive Diabetes Care—HbA1c Testing

♦ In Q3 and Q4 2019, in-home member screening services (MedXM) were ongoing in all seven Health Net counties. The table below shows gap closure for HbA1c testing in San Joaquin County up through Q4 2019.

<table>
<tr><th>County</th><th>Q3 2019 Gaps Closed through MedXM</th><th>Q4 2019 Gaps Closed through MedXM</th></tr>
<tr><td>San Joaquin</td><td>31</td><td>38</td></tr>
</table>

♦ Health Net continued the in-home health assessment program, MedXM, in all seven Health Net counties to outreach to all non-compliant *Comprehensive Diabetes Care* members in measurement year 2019. The data were prioritized to identify 80 percent or more of our members who reside in high-volume ZIP Codes to aid the technician in greater outreach.

♦ Health Net conducted Community Resource Center (CRC) Health Screening Days. Health Net arranged for regularly scheduled health screening days for diabetes care, well-child visits, and breast cancer screenings. The screenings were held on August 24, September 27, and November 15, 2019, at the Health Net CRC in Stockton. Members who completed their *Comprehensive Diabetes Care* screening, including all three sub-measures (*Eye Exam [Retinal] Performed*, *Medical Attention for Nephropathy*, and *HbA1c Testing)*, received a $50 point-of-care incentive.

♦ The HEDIS team performed live calls to non-compliant members from San Joaquin, Sacramento, Kern, and Stanislaus counties to offer a member incentive and provide scheduling assistance.

</td></tr>
</table>

2018–19 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ Health Net engaged providers to participate in one-stop events to close gaps. One-stop screening events were held in several counties, including San Joaquin County. Members received screenings, and HEDIS measures were completed. The table below shows the number of events and members seen in San Joaquin County. County / One-Stop Events / Members Seen: **San Joaquin** / 3 / 54 ♦ The Health Education Department conducted phone education and appointment scheduling to help non-compliant members understand the importance of preventive health services (immunizations, diabetes screenings, well-child visits, and breast and cervical cancer screenings) and schedule the members to attend a one-stop, point-of-care, or community health-screening event. In addition, the Health Education Department conducted screening events, such as "Know Your Number Plus," in community settings to increase screening opportunities for non-compliant members who face various barriers to health care access (geographical, transportation, language, availability, affordability, and acceptability). The department collaborated with the quality improvement team to leverage Alinea and MedXM to offer mammograms, diabetes screenings (HbA1c testing), and well-care visits. ♦ In Q1 and Q2 2020, clinic staff members utilized care gap lists to target patient outreach for members in San Joaquin County to visit their PCP and get lab work completed. This was part of a continued PDSA process. The clinic was able to schedule 19 patients, which was a 14.2 percent completion rate.

2018–19 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ Health Net continued the in-home health assessment program (MedXM) in San Joaquin and Stanislaus counties to outreach to non-compliant *Comprehensive Diabetes Care* members in measurement year 2019. Program deployment was targeted for Q2 2020. ♦ Health Net continued distribution of U.S. Medical Management, LLC (USMM) home mailing kits for HbA1c testing in Kern, Sacramento, San Joaquin, Stanislaus, and Tulare counties. ♦ Health Net continued the one-stop clinic program which provided extended clinic hours (hours outside of regular business), supported by the MCP, to address member care needs for targeted populations facing barriers to accessing care. ♦ Health Net engaged with and provided complex support to providers/clinic sites to implement weekend and extended-hour clinics. Five clinics have been completed to date. ♦ Due to COVID-19 restrictions, the *Comprehensive Diabetes Care* PDSA did not continue into another cycle. ♦ Health Net distributed incentives to members who had services completed in 2019 through Q2 2020. This program ended June 30, 2020. The planned launch for 2020 Medi-Cal Member Reward Cards is Q3 2020, pending DHCS approval for this program. ♦ The HEDIS team completed live outreach calls to non-compliant members for HbA1c testing in San Joaquin, Kern, and San Diego counties. The team offered home testing kits through USMM. The total number of members identified for outreach was 2,882, with an average reach rate of 42 percent. These calls concluded in early July 2020.

2018–19 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
♦ *Prenatal and Postpartum Care—Postpartum Care* in Los Angeles County (The rate for this measure was also below the minimum performance level in reporting year 2018 for this reporting unit.)	***Prenatal and Postpartum Care*** ♦ In Q3 and Q4 2019, outreach was completed to identify members who delivered a baby. Home visits were conducted to members not reached by live calls in Los Angeles, Sacramento, San Joaquin, and Stanislaus counties. ♦ In Q1 and Q2 2020, Health Net engaged with a high-volume Participating Physician Group (PPG) in Los Angeles County to identify the root causes of the data gap for postpartum care (strategy for postpartum SWOT [Strengths, Weaknesses, Opportunities, Threats] analysis). Health Net continued with the postpartum SWOT analysis in Los Angeles County and is implementing the following three strategies in this county: ■ Identify members who just delivered a baby for phone outreach through the Member Retention Team. Members not reached by the Member Retention Team are referred to Member Connections for home visits. The Member Retention and Member Connections representatives ensure that the member has a timely postpartum appointment. If needed, the member is referred to local resources for social support. This strategy continues, although Member Connections is not doing home visits as of March 10, 2020, due to COVID-19. ■ Educate PPGs and providers about the new *Prenatal and Postpartum Care* measure HEDIS technical specifications and best practices. This strategy is also on hold as Provider Relations staff members are not visiting provider offices due to COVID-19. ■ Target a high-volume, low-performing PPG in Los Angeles County to identify and resolve data challenges to address the data gap. This strategy continues through phone/web-based meetings.

<table>
<tr><th>2018–19 External Quality Review Recommendations Directed to Health Net</th><th>Self-Reported Actions Taken by Health Net during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations</th></tr>
<tr><td>♦ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life in San Joaquin County (The rates for this measure have been below the minimum performance levels for more than three consecutive years in this reporting unit.)</td><td>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
♦ CRC Health Screening Days: Health Net arranges for regularly scheduled health screening days for diabetes care, well-child visits, and breast cancer screenings. Screenings were held on August 24, September 27, and November 15, 2019, at the Health Net CRC in Stockton. Members who completed their Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life visit received a $25 point-of-care incentive.
♦ The HEDIS team completed call outreach to non-compliant members from San Joaquin, Sacramento, Kern, and Stanislaus counties to offer a member incentive and provide scheduling assistance.
♦ One-stop clinics with high-volume providers will remain active for select weekends to increase access to care and complete Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life care gaps. MedXM completed in-home outreach to and appointment scheduling for members without a visit in 2019 or 2018. One-stop screening events were held in several counties. Members received screenings, and HEDIS measures were completed. The table below shows the number of events and members seen in San Joaquin County.
<table><tr><th>County</th><th>One-Stop Events</th><th>Members Seen</th></tr><tr><td>San Joaquin</td><td>3</td><td>54</td></tr></table>
♦ The Health Education Department completed phone education and appointment scheduling to help non-compliant members understand the importance of preventive health services (immunizations, diabetes screenings, well-child visits, and breast and cervical cancer screenings)</td></tr>
</table>

2018–19 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	and schedule the members to attend a one-stop, point-of-care, or community health-screening event. ♦ Health Net continued the one-stop clinic program which provided extended clinic hours (hours outside of regular business), supported by the MCP, to address member care needs for targeted populations facing barriers to accessing care. ♦ Health Net engaged with and provided complex support to providers/clinic sites to implement weekend and extended-hour clinics. Health Net has completed 106 screenings to date. ♦ The Health Education Department conducted screening events in community settings to increase screening opportunities for non-compliant members who face barriers to health care access (geographical, transportation, language, availability, affordability, and acceptability). The department collaborated with the quality improvement team to leverage Alinea and MedXM to offer mammograms, diabetes screenings (HbA1c testing), and well-care visits. ♦ In Q1 and Q2 2020, in-home member screening services (MedXM) in all seven Health Net counties continued. ♦ Health Net completed PDSA testing and follow-up HEDIS outreach calls to parents of members from previous *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* outreach efforts. This included members who were still non-compliant as of November 2019. At the end of the outreach, 26 percent of parents of non-compliant members reported intent to schedule or were assisted in scheduling well-child appointments. ♦ Health Net offered incentives for non-compliant members (in all Health Net counties) for closing gaps in care. This continued deployment of the Medi-Cal Member Reward Cards Program is the main program in 2020 that Health Net will use to

2018–19 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	incentivize members to follow through with getting needed health care services. The member incentive program continues to fulfill members' requests. This is a multichannel outreach effort to non-compliant members to reward completion of individually defined health care activities. Planned deployment in Q1 2020 was postponed due to a delayed approval process with DHCS. In January and early February, the MCP supported scheduled events with incentive distribution. ♦ COVID-19 restrictions continue to impact access to care and preventive health services due to concerns about face-to-face visits for these appointments. Due to these restrictions, the PDSA for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure did not continue into another cycle. ♦ Health Net distributed rewards for members who had services rendered in 2019 through Q2 of 2020. This program ended June 30, 2020. The planned launch for 2020 Medi-Cal Member Reward Cards is Q3 2020, pending DHCS approval for this program.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Health Net's self-reported actions in Table 8.1 and determined that Health Net adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. Health Net indicated that it worked with DHCS to resolve all findings from the 2018 A&I Medical and State Supported Services Audits and described in detail actions taken during the review period to improve performance to above the minimum performance levels. The MCP provided descriptions of various interventions it implemented, including:

- Conducting:
  - Member outreach.
  - In-home visits.
  - Mobile screening events.
  - Member education.

- Offering:
  - Member incentives.
  - Appointment scheduling assistance.
  - Weekend and extended-hour clinics.

2019–20 Recommendations

Based on the overall assessment of Health Net's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Update the MCP's enrollment determinations to monthly spans and implement dual eligibility calculations to ensure that dual eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.
- Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 PIPs.
- Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adapted interventions and to strengthen future quality improvement efforts.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix Q:
Performance Evaluation Report
Health Net of California, Inc.
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS' contracted Medi-Cal dental managed care (DMC) plan, Health Net of California, Inc. ("Health Net" or "the DMC plan"). The purpose of this appendix is to provide DMC plan-specific results of each activity and an assessment of the DMC plan's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to dental care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under the Medi-Cal Managed Care program (MCMC), and the term "member" refers to a person enrolled in a DMC plan. The review period for this DMC plan-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in Health Net's 2020–21 plan-specific evaluation report. This DMC plan-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Dental Managed Care Plan Overview

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

Health Net became operational as a DMC plan in Los Angeles County effective July 1, 2013, and in Sacramento County effective January 1, 2013. As of June 2020, Health Net had 171,934 members in Los Angeles County and 132,274 in Sacramento County—for a total of 304,208 members.[1] This represents 47 percent of the DMC beneficiaries enrolled in Los Angeles County and 31 percent of DMC beneficiaries enrolled in Sacramento County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

Compliance Reviews Conducted

The following is a summary of the most recent review conducted for Health Net. HSAG's compliance review summaries are based on final audit reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020). The description of the DHCS Audits and Investigations Division (A&I) Dental Audit may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site A&I Dental Audit of Health Net. A&I conducted the audit from March 16, 2020, through March 19, 2020. DHCS issued the final closeout letter on September 24, 2020, which is outside the review period for this report; however, HSAG includes the information from the letter because it reflects full resolution of the findings from the March 2020 A&I Dental Audit.

Table 2.1—DHCS A&I Dental Audit of Health Net
Audit Review Period: March 1, 2019, through February 29, 2020

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

Strengths—Compliance Reviews

A&I identified no findings in the Access and Availability of Care and Member's Rights categories during the March 2020 Dental Audit of Health Net. In response to the CAP from this audit, Health Net submitted documentation to DHCS that resulted in the CAP being closed. The documentation summarized the changes Health Net made to its policies and procedures to ensure the DMC plan is fully compliant with DHCS contract requirements in the Utilization Management and Quality Management categories.

Opportunities for Improvement—Compliance Reviews

Health Net has no outstanding findings from the March 2020 A&I Dental Audit; therefore, HSAG has no recommendations for the DMC plan in the area of compliance reviews.

3. Dental Managed Care Plan Performance Measures

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

Beginning with reporting year 2019, DHCS required DMC plans to submit both reporting units' audited performance measure rates reflecting measurement year data from the previous calendar year. In May 2020, Health Net submitted to DHCS both reporting units' reporting year 2020 performance measure rates reflecting measurement year 2019 data (i.e., January 1, 2019, through December 31, 2019).

Performance Measure Results

Table 3.1 and Table 3.2 present Health Net's reporting years 2019 and 2020 audited performance measure rates by domain for each DMC plan reporting unit. To allow HSAG to provide meaningful display of DMC plan performance, HSAG organized the performance measures according to health care areas that each measure affects (i.e., Access to Care and Preventive Care).

Table 3.1—Reporting Years 2019 and 2020 (Measurement Years 2018 and 2019) Dental Managed Care Plan Performance Measure Results
Health Net—Los Angeles County

= Statistical testing result indicates that the reporting year 2020 rate is significantly better than the reporting year 2019 rate.

= Statistical testing result indicates that the reporting year 2020 rate is significantly worse than the reporting year 2019 rate.

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

Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

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

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Access to Care			
Annual Dental Visits—Ages 0–20 Years	37.96%	38.14%	0.18
Annual Dental Visits—Ages 21+ Years	19.16%	19.49%	0.33
Continuity of Care—Ages 0–20 Years	64.18%	67.99%	3.81
Continuity of Care—Ages 21+ Years	34.75%	38.32%	3.58
Exam/Oral Health Evaluations—Ages 0–20 Years	33.70%	34.03%	0.32
Exam/Oral Health Evaluations—Ages 21+ Years	15.27%	15.46%	0.19
General Anesthesia—Ages 0–20 Years	41.18%	36.93%	-4.25
General Anesthesia—Ages 21+ Years	31.17%	26.02%	-5.14
Overall Utilization of Dental Services—One Year—Ages 0–20 Years	42.85%	43.48%	0.63
Overall Utilization of Dental Services—One Year—Ages 21+ Years	19.55%	19.70%	0.15
Use of Dental Treatment Services—Ages 0–20 Years	17.07%	17.75%	0.67
Use of Dental Treatment Services—Ages 21+ Years	11.61%	11.71%	0.11
Usual Source of Care—Ages 0–20 Years	32.88%	32.28%	-0.59
Usual Source of Care—Ages 21+ Years	8.86%	9.51%	0.65
Preventive Care			
Preventive Services to Filling—Ages 0–20 Years	80.54%	81.76%	1.23
Preventive Services to Filling—Ages 21+ Years	26.10%	29.23%	3.13
Sealants to Restoration Ratio (Surfaces)—Ages 6–9 Years	6.06	6.78	0.73

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Sealants to Restoration Ratio (Surfaces)—Ages 10–14 Years	2.66	2.63	-0.04
Treatment/Prevention of Caries—Ages 0–20 Years	24.22%	24.77%	0.55
Treatment/Prevention of Caries—Ages 21+ Years	6.07%	6.27%	0.19
Use of Preventive Services—Ages 0–20 Years	32.27%	32.56%	0.29
Use of Preventive Services—Ages 21+ Years	7.73%	7.92%	0.19
Use of Sealants—Ages 6–9 Years	13.56%	13.68%	0.12
Use of Sealants—Ages 10–14 Years	5.82%	5.89%	0.06

Table 3.2—Reporting Years 2019 and 2020 (Measurement Years 2018 and 2019) Dental Managed Care Plan Performance Measure Results
Health Net—Sacramento County

= Statistical testing result indicates that the reporting year 2020 rate is significantly better than the reporting year 2019 rate.

= Statistical testing result indicates that the reporting year 2020 rate is significantly worse than the reporting year 2019 rate.

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

Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

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

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Access to Care			
Annual Dental Visits—Ages 0–20 Years	37.44%	39.37%	1.93
Annual Dental Visits—Ages 21+ Years	19.44%	19.39%	-0.05
Continuity of Care—Ages 0–20 Years	67.54%	69.88%	2.34
Continuity of Care—Ages 21+ Years	36.48%	39.95%	3.47
Exam/Oral Health Evaluations—Ages 0–20 Years	33.18%	35.66%	2.48
Exam/Oral Health Evaluations—Ages 21+ Years	14.36%	14.44%	0.08
General Anesthesia—Ages 0–20 Years	67.24%	62.79%	-4.44
General Anesthesia—Ages 21+ Years	26.74%	15.26%	-11.49
Overall Utilization of Dental Services—One Year—Ages 0–20 Years	45.33%	47.32%	2.00
Overall Utilization of Dental Services—One Year—Ages 21+ Years	22.10%	21.82%	-0.28
Use of Dental Treatment Services—Ages 0–20 Years	21.38%	24.09%	2.71
Use of Dental Treatment Services—Ages 21+ Years	13.29%	13.49%	0.20
Usual Source of Care—Ages 0–20 Years	33.99%	35.47%	1.48
Usual Source of Care—Ages 21+ Years	11.15%	12.17%	1.02
Preventive Care			
Preventive Services to Filling—Ages 0–20 Years	83.45%	86.73%	3.28
Preventive Services to Filling—Ages 21+ Years	36.89%	38.67%	1.79
Sealants to Restoration Ratio (Surfaces)—Ages 6–9 Years	5.36	6.02	0.66

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Sealants to Restoration Ratio (Surfaces)—Ages 10–14 Years	2.16	1.96	-0.20
Treatment/Prevention of Caries—Ages 0–20 Years	28.18%	30.95%	2.76
Treatment/Prevention of Caries—Ages 21+ Years	7.66%	8.50%	0.84
Use of Preventive Services—Ages 0–20 Years	32.54%	35.11%	2.57
Use of Preventive Services—Ages 21+ Years	8.18%	8.96%	0.78
Use of Sealants—Ages 6–9 Years	14.06%	14.77%	0.71
Use of Sealants—Ages 10–14 Years	6.93%	7.03%	0.09

Strengths—Performance Measures

Health Net had no measures with rates that declined significantly from reporting year 2019 to reporting year 2020; across both reporting units, 20 rates improved significantly from reporting year 2019 to reporting year 2020. Los Angeles County had eight measures with rates that improved significantly, and Sacramento County had 12 measures with rates that improved significantly.

Access to Care

Across both reporting units within the Access to Care health care area, 12 of 28 measure rates (43 percent) improved significantly from reporting year 2019 to reporting year 2020. These measures are listed below:

- *Annual Dental Visits—Ages 0–20 Years* in Sacramento County
- *Annual Dental Visits—Ages 21+ Years* in Los Angeles County
- Both *Continuity of Care* measures in both reporting units
- *Exam/Oral Health Evaluations—Ages 0–20 Years* in Sacramento County
- *Overall Utilization of Dental Services—One Year—Ages 0–20 Years* in both reporting units
- *Usual Source of Care—Ages 0–20 Years* in Sacramento County
- *Usual Source of Care—Ages 21+ Years* in both reporting units

Preventive Care

Across both reporting units within the Preventive Care health care area, eight of 20 measure rates (40 percent) improved significantly from reporting year 2019 to reporting year 2020. These measures are listed below:

- *Preventive Services to Filling—Ages 0–20 Years* in Sacramento County
- *Preventive Services to Filling—Ages 21+ Years* in Los Angeles County
- Both *Treatment/Prevention of Caries* measures in both reporting units
- Both *Use of Preventive Services* measures in Sacramento County

Opportunities for Improvement—Performance Measures

Based on Health Net's reporting year 2020 performance measure results, HSAG has no recommendations for the DMC plan in the area of performance measures.

4. Performance Improvement Projects

DHCS requires DMC plans to conduct two quality improvement projects (QIPs) per year. DMC plans must participate in a DHCS-established and facilitated statewide QIP as well as an individual QIP that aligns with a demonstrated area in need of improvement. For the statewide QIP, DMC plans must submit two reports annually—one intervention progress report to HSAG, and an annual QIP submission to DHCS. For the individual QIP, DMC plans must use HSAG's rapid-cycle performance improvement project (PIP) process. Because DHCS requires DMC plans to use HSAG's rapid-cycle PIP process for their individual QIPs, HSAG refers to DMC plans' individual QIPs as individual PIPs.

Statewide Quality Improvement Project

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

Based on the reporting requirements, Health Net submitted its second annual intervention progress report to HSAG in January 2020. The DMC plan reported on identified barriers and interventions conducted as of December 31, 2019. In February 2020, HSAG provided feedback to Health Net on the intervention progress report. HSAG noted that Health Net had methods for evaluating interventions and provided evaluation data. While Health Net indicated that the interventions have been successful, the DMC plan did not meet the QIP goal.

HSAG suggested that Health Net should:

- In the next annual intervention progress report, address all feedback and recommendations HSAG made in the last two consecutive annual intervention progress reports; and provide an updated causal/barrier analysis and key driver diagram.
- Revisit the causal/barrier analysis at least annually to reassess barriers; and in the next annual intervention progress report, provide a comprehensive list of the identified barriers ranked in order of priority.
- Link the interventions with identified barriers to ensure that the interventions will directly impact the QIP outcomes.

Individual Performance Improvement Project

Rapid-Cycle Performance Improvement Project Overview

The following is an overview of HSAG's rapid-cycle PIP process that DMC plans followed when conducting their individual PIPs.

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

The following provides an overview of the Rapid-Cycle PIP modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Individual Performance Improvement Project Results and Findings

Using its own DMC plan-specific data, Health Net selected coordination of care for high-risk members as its 2019–21 individual PIP topic. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the DMC plan's module submissions for the 2019–21 individual PIP as well as validation findings from the review period.

During the review period of this report, HSAG validated modules 1 through 3 for the DMC plan's *Coordination of Care for High-Risk Members* PIP. Upon initial review of Module 1, HSAG determined that Health Net met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of:
  - The SMART Aim statement.
  - The SMART Aim data collection methodology.
  - The SMART Aim run chart.

After receiving technical assistance from HSAG, Health Net incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the DMC plan met all validation criteria for Module 1. Health Net met all validation criteria for modules 2 and 3 in the DMC plan's initial submission.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the DMC plan's *Coordination of Care for High-Risk Members* PIP.

Table 4.1—Health Net *Coordination of Care for High-Risk Members* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of deep cleanings or periodontal maintenance procedures completed among members ages 65 to 85 who are living with diabetes and identified as high-risk	5.17%	10.00%

Table 4.2 presents a description of the intervention that Health Net selected to test for its *Coordination of Care for High-Risk Members* PIP. The table also indicates the failure mode that the intervention aims to address.

Table 4.2—Health Net *Coordination of Care for High-Risk Members* PIP Intervention Testing

Intervention	Failure Mode Addressed
Conduct text message outreach using a series of member engagement messages to inform members living with diabetes about the benefits of having deep cleanings or periodontal maintenance completed	Members do not receive any information about the importance of having a deep cleaning or periodontal maintenance completed when living with diabetes

While Health Net advanced to the intervention testing phase, the PIP did not progress to the point where the DMC plan was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Health Net successfully completed the second annual intervention progress report for the *Preventive Services Utilization* statewide QIP. Additionally, using information gained from HSAG's PIP training, validation results, and technical assistance, Health Net submitted all required documentation and met all criteria for the *Coordination of Care for High-Risk Members* individual PIP modules that the DMC plan completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each DMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 DMC plan-specific evaluation report. Based on HSAG's assessment of Health Net Dental's delivery of quality, accessible, and timely care through the activities described in the DMC plan's 2018–19 DMC plan-specific evaluation report, HSAG included no recommendations in Health Net Dental's 2018–19 DMC plan-specific evaluation report. Therefore, Health Net Dental had no recommendations for which it was required to provide the DMC plan's self-reported actions.

2019–20 Recommendations

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

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix R:
Performance Evaluation Report
Health Plan of San Joaquin
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Health Plan of San Joaquin ("HPSJ" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in HPSJ's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

HPSJ is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in HPSJ, the Local Initiative MCP, or in Health Net Community Solutions, Inc., the alternative commercial plan.

HPSJ became operational in San Joaquin County to provide MCMC services effective February 1996 and in Stanislaus County effective January 2013. As of June 2020, HPSJ had 210,589 members in San Joaquin County and 132,710 in Stanislaus County—for a total of 343,299 members.[1] This represents 92 percent of the beneficiaries enrolled in San Joaquin County and 69 percent in Stanislaus County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for HPSJ. HSAG's compliance review summaries are based on final audit/survey reports issued on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of HPSJ. A&I conducted the audits from August 12, 2019, through August 16, 2019.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of HPSJ
Audit Review Period: July 1, 2018, through June 30, 2019

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

Strengths—Compliance Reviews

During the audits, A&I assessed HPSJ's initiatives related to the prior year's audit findings in the Member's Rights and Administrative and Organizational Capacity categories and determined that due to system improvements HPSJ made, the MCP was able to:

- Submit 24-hour notifications and Privacy Incident Reports for Health Insurance Portability and Accountability Act of 1996 incidents to DHCS within the required time frames.
- Report all fraud incidents to DHCS appropriately and in a timely manner.

Opportunities for Improvement—Compliance Reviews

A&I identified no findings during the 2019 Medical and State Supported Services Audits of HPSJ; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures HPSJ chose to report using one or both of these two options.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a corrective action plan (CAP) for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of HPSJ, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Health Plan of San Joaquin* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.8 for HPSJ's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.8:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 and Table 3.2 present the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
HPSJ—San Joaquin County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	42.82%
Childhood Immunization Status—Combination 10	41.61%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	94.39%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	86.62%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	87.31%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	84.84%
Developmental Screening in the First Three Years of Life—Total	17.43%
Immunizations for Adolescents—Combination 2	46.47%

Measure	Reporting Year 2020 Rate
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	86.37%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	54.99%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.80%

Table 3.2—Children's Health Domain
Reporting Year 2020 Performance Measure Results
HPSJ—Stanislaus County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	40.63%
Childhood Immunization Status—Combination 10	30.66%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	94.30%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	85.33%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	86.17%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	82.97%
Developmental Screening in the First Three Years of Life—Total	12.49%
Immunizations for Adolescents—Combination 2	33.82%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	86.37%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	43.31%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.59%

Women's Health Domain

Table 3.3 and Table 3.4 present the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.3—Women's Health Domain
Reporting Year 2020 Performance Measure Results
HPSJ—San Joaquin County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	55.89%
Cervical Cancer Screening	63.99%
Chlamydia Screening in Women—Ages 16–20 Years	60.57%
Chlamydia Screening in Women—Ages 21–24 Years	70.83%
Chlamydia Screening in Women—Total	65.28%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	16.58%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.25%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.26%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.72%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	7.72%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	34.97%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	37.83%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	7.65%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	6.63%
Prenatal and Postpartum Care—Postpartum Care	79.56%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.10%

Table 3.4—Women's Health Domain
Reporting Year 2020 Performance Measure Results
HPSJ—Stanislaus County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	61.26%
Cervical Cancer Screening	54.74%
Chlamydia Screening in Women—Ages 16–20 Years	51.23%
Chlamydia Screening in Women—Ages 21–24 Years	68.53%
Chlamydia Screening in Women—Total	59.97%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	18.20%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	28.97%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.26%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.88%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.06%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	43.40%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.67%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	11.79%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.90%
Prenatal and Postpartum Care—Postpartum Care	79.81%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.75%

Behavioral Health Domain

Table 3.5 and Table 3.6 present the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.5—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
HPSJ—San Joaquin County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	50.97%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	33.18%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	42.95%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	56.98%

Measure	Reporting Year 2020 Rate
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.24%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Table 3.6—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
HPSJ—Stanislaus County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	51.35%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	35.09%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	25.00%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	37.78%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.00%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.05%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.7 and Table 3.8 present the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.7—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
HPSJ—San Joaquin County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	89.05%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	46.82
Asthma Medication Ratio—Total	59.49%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	32.85%
Comprehensive Diabetes Care—HbA1c Testing—Total	87.10%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	17.10%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	65.21%
HIV Viral Load Suppression—Ages 18–64 Years	S
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.76%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.77%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.79
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.43%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S

Table 3.8—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
HPSJ—Stanislaus County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	91.73%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	52.19
Asthma Medication Ratio—Total	63.12%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	35.77%
Comprehensive Diabetes Care—HbA1c Testing—Total	88.32%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	21.13%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	64.96%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.15%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.52%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.86
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.24%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S

Assessment of Corrective Action Plan—Acute and Chronic Disease Management Domain

In April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that HPSJ conducted as part of its CAP prior to April 2020.

Based on reporting year 2019 performance measure results in San Joaquin County, the following two measures within the Acute and Chronic Disease Management domain were included in HPSJ's CAP:

- *Asthma Medication Ratio—Total*
- *Comprehensive Diabetes Care—HbA1c Testing—Total*

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of HPSJ's performance related to the two measures within the Acute and Chronic Disease Management domain for which the MCP conducted PDSA cycles.

Asthma Medication Ratio—Total

DHCS approved HPSJ to conduct PDSA cycles to address the MCP's performance below the minimum performance level for the *Asthma Medication Ratio—Total* measure in San Joaquin County.

HPSJ's population health team conducted a scripted outreach call campaign to members who were one prescription refill away from meeting the prescribed rescue versus controller asthma medication ratio. During the outreach calls, HPSJ reminded members to refill their prescriptions and offered assistance with scheduling medication refill appointments with providers and arranging transportation to the appointments. HPSJ reported learning that educating members about the use of controller medications with an emphasis on asthma symptom management and preventing hospitalization may be an effective strategy for improving the controller medication prescription refill rate.

Comprehensive Diabetes Care—HbA1c Testing—Total

DHCS approved HPSJ to conduct PDSA cycles to address the MCP's performance below the minimum performance level for the *Comprehensive Diabetes Care—HbA1c Testing—Total* measure in San Joaquin County.

HPSJ's case management staff members conducted a scripted outreach call campaign to members identified through a gap-in-care report to emphasize the importance of completing their HbA1c testing. During the calls, HPSJ offered the members educational materials and disease management services and informed them that they would receive a $25 gift card upon completion of their appointments. Additionally, HPSJ offered these members assistance with scheduling appointments and arranging transportation to the appointments. HPSJ reported

learning that including several components in the intervention and conducting the components sequentially helped to improve HbA1c testing compliance among members living with diabetes.

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the “Reporting Year 2020 Quality Monitoring and Corrective Action Plans” heading in this section, DHCS determined to require MCPs to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP’s strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. In lieu of conducting PDSA cycles on one MCAS measure, DHCS approved HPSJ to conduct a SWOT analysis quality improvement project to address multiple MCAS measures within the Children’s Health domain. The SWOT analysis methodology provides a systemic approach for implementing multiple interventions and evaluating progress at specified time intervals. Thus, HPSJ will be required to conduct a SWOT analysis on multiple Children’s Health domain measures as well as to develop and submit a COVID-19 QIP.

Note that in September 2020, DHCS notified HPSJ that DHCS was closing the MCP’s CAP, which was based on DHCS’ previous performance measure set (External Accountability Set). To ensure continued monitoring of HPSJ’s performance, DHCS will require HPSJ to meet quarterly via telephone with the MCP’s assigned DHCS nurse consultant. While DHCS notified HPSJ of the CAP closure outside the review period for the MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.9 and Table 3.10 present the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.9—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations HPSJ—San Joaquin County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	79.78	44.16	Not Tested	46.82
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	100.00%	94.34%	5.66	94.39%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	88.85%	86.56%	2.29	86.62%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	92.21%	87.13%	5.08	87.31%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	86.71%	84.77%	1.94	84.84%
*Plan All-Cause Readmissions—Total***	9.47%	6.89%	2.58	7.76%

Table 3.10—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations HPSJ—Stanislaus County

[Green] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

[Red] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	93.28	49.68	Not Tested	52.19
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	94.37%	Not Comparable	94.31%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	93.83%	85.14%	8.69 [Green]	85.33%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	91.19%	86.02%	5.17 [Green]	86.17%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	87.33%	82.84%	4.49	82.97%
*Plan All-Cause Readmissions— Total***	10.65%	7.25%	3.40	8.15%

Seniors and Persons with Disabilities—Performance Measure Findings

For reporting year 2020, for measures that HPSJ stratified by the SPD and non-SPD populations and for which HSAG could compare reporting year 2020 SPD rates to non-SPD rates, HSAG observed the following notable results:

- The reporting year 2020 SPD rates were significantly better than the reporting year 2020 non-SPD rates for the following measures:
  - *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years* in Stanislaus County.
  - *Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years* in both San Joaquin and Stanislaus counties.
  - *Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years* in Stanislaus County.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020 in both San Joaquin and Stanislaus counties. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

HPSJ reported lessons learned from the PDSA cycles the MCP conducted to improve its performance on the *Asthma Medication Ratio—Total* and *Comprehensive Diabetes Care—HbA1c Testing—Total* measures that it can apply to future quality improvement efforts.

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, HPSJ submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, HPSJ initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, HPSJ identified cervical cancer screening among White women, ages 24 to 64, residing in Stanislaus County as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure results reported by the MCP for its *Cervical Cancer Screening* Disparity PIP.

Table 4.1—HPSJ *Cervical Cancer Screening* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of cervical cancer screening compliance among White women, ages 24 to 64, residing in Stanislaus County	44.75%	49.20%	No

Table 4.2 presents a description of the interventions that HPSJ tested for its *Cervical Cancer Screening* Disparity PIP. The table also indicates the key drivers and failure modes that the interventions addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—HPSJ *Cervical Cancer Screening* Disparity PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Conduct a call campaign to provide appointment scheduling and transportation assistance	♦ Data integrity ♦ Access ♦ Communication ♦ Resources ♦ Education ♦ Members are unable to schedule cervical cancer screening appointments ♦ Members do not know when to have a cervical cancer screening ♦ Members fail to schedule a cervical cancer screening ♦ Members are unaware of the importance of having the screening done ♦ Members lack adequate transportation to the appointment	Adapt
Partner with a federally qualified health center (FQHC) to offer a clinic day once a month to provide incentives to members who complete their cervical cancer screenings		

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for HPSJ's *Cervical Cancer Screening* Disparity PIP. HPSJ documented in the modules that it tested two interventions. HPSJ's call center tested the effectiveness of offering appointment scheduling and transportation assistance to members who were due for their cervical cancer screenings. While HPSJ determined that the outreach call campaign was not as impactful as anticipated, the MCP found some success in the tested intervention and decided to continue the calls with process modifications. HPSJ also tested a partnership with an FQHC to offer at least one clinic day each month dedicated to HPSJ members. The intervention included incentives to members who completed their cervical cancer screenings on the clinic day. The MCP determined that the incentive offer motivated members to attend the clinic days and complete their screenings. HPSJ decided to adapt the FQHC clinic day intervention. Despite HPSJ's efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned HPSJ's *Cervical Cancer Screening* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on HPSJ's reporting year 2017 performance measure results, the MCP selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure results as reported by the MCP for its *Childhood Immunization Status—Combination 3* PIP.

Table 4.3—HPSJ *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of *Childhood Immunization Status—Combination 3* compliance among members residing in San Joaquin County who have Medical Center A[6] as their primary care provider	5.11%	20.00%	Yes

Table 4.4 presents a description of the intervention that HPSJ tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the failure mode that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.4—HPSJ *Childhood Immunization Status—Combination 3* PIP Intervention Testing Results

Intervention	Failure Mode Addressed	Adopt, Adapt, Abandon, or Continue Testing
Make outreach calls and send text messages to the parents of non-compliant members	Parents do not understand the importance of having their children immunized	Abandon

[6] Medical center name removed for confidentiality.

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for HPSJ's *Childhood Immunization Status—Combination 3* PIP. HPSJ documented in the modules that it tested having the provider partner make outreach calls to the parents of members who were due for their immunizations to schedule appointments and following the outreach calls to send appointment reminder text messages. While HPSJ achieved the SMART Aim goal, the MCP documented that its provider partner experienced challenges providing the intervention effectiveness data; therefore, the MCP could not assess the impact of the tested intervention on the SMART Aim measure. The MCP determined to abandon the intervention.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned HPSJ's *Childhood Immunization Status—Combination 3* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, HPSJ determined to continue its focus on cancer screening among White women, ages 24 to 64, residing in Stanislaus County as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Cervical Cancer Screening* Health Equity PIP. Upon initial review of the modules, HSAG determined that HPSJ met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- ♦ Including all required components of the SMART Aim data collection methodology.
- ♦ Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.
- ♦ Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- ♦ Labeling clearly the identified gaps or opportunities for improvement in the process map steps.
- ♦ Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- ♦ Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.

After receiving technical assistance from HSAG, HPSJ incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. HPSJ was in the process of working on its Module 2 resubmission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, HPSJ selected adolescent well-care visits as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Adolescent Well-Care Visits* PIP. Upon initial review of the modules, HSAG determined that HPSJ met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Supporting the narrowed focus with data.
- Including all required components of the SMART Aim statement, SMART Aim data collection methodology, and SMART Aim run chart.
- Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.

After receiving technical assistance from HSAG, HPSJ incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. HPSJ was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, HPSJ identified interventions that it can adapt to improve cervical cancer screening compliance among female members.

Opportunities for Improvement—Performance Improvement Projects

HPSJ has the opportunity to monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Cervical Cancer Screening* Disparity PIP. The MCP should apply lessons learned from the 2017–19 PIPs to strengthen future quality improvement efforts.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

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

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

HPSJ submitted the MCP's final PNA report to DHCS on July 23, 2020, and DHCS notified the MCP via email on the same day that DHCS approved the report as submitted. While HPSJ submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 7.1 provides EQR recommendations from HPSJ's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of HPSJ's self-reported actions.

Table 7.1—HPSJ's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Identify the causes for the *Asthma Medication Ratio* measure rate declining significantly from reporting year 2018 to reporting year 2019 in both reporting units and develop strategies, as applicable, to address the causes for the significant decline, which resulted in the rate in San Joaquin County moving to below the minimum performance level in reporting year 2019.	♦ HPSJ determined that the cause of the *Asthma Medication Ratio* measure rates declining in both counties was attributed primarily to significant rate decline in both adult and child age bands. We suspect more rescue inhalers were filled due to the massive wildfires in California and hazardous air quality in the San Joaquin Valley. We also identified trends in caretakers filling extra reliever medications for children so inhalers could be kept at school for the children when needed. ♦ HPSJ formed a workgroup to address the needs of members with acute and chronic conditions. This ad hoc group focused on strengthening member linkages to the San Joaquin and Stanislaus County Asthma Coalitions to expand in-home asthma visitation. The Asthma Coalition emphasizes the importance of long-term asthma management and evaluates the patients' home environments.

2018–19 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ HPSJ increased the emphasis of asthma controller medication in member education in newsletters. ♦ HPSJ placed a soft stop on dispensing rescue medications in the absence of controllers at the time of refill. ♦ DHCS implemented the Value-Based Payment (VBP) Program to incentivize providers to prescribe according to recommended standards of care. ♦ COVID-19 halted all in-home asthma visitation by the Asthma Coalition in March 2020. While rates improved in the adult population in reporting year 2020, rates continue to trend down in the child population. It is possible that COVID-19 and shelter-in-place will have a positive impact on the *Asthma Medication Ratio* rate in children for measurement year 2020. ♦ HPSJ noted that child rates are lower. This may be based on the identified practice of pharmacies and prescribers allowing refills of rescue inhalers for the purpose of supplying rescue inhalers for school use. COVID-19 shelter in place dictates that children are at home. When children are at home, the need to supply backup rescue inhalers is no longer a consideration. The vast majority of inhalers are used in the home setting. ♦ Because there was a direct relationship between the members' inability to fill their controller medications and providers' inability to educate and provide support to increase adherence to the medical treatment regimen, it was decided that the most practical intervention was to target those members who were close to meeting the ratio and were only missing one more prescription refills of their controller medications by placing reminder

2018–19 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	calls to these members. The calls also reminded members to call their providers for an appointment so they can receive appropriate education about how they can better manage their asthma attacks. ■ The October 2019 gap report showed that 2,567 of the 2,745 eligible members were compliant for the *Asthma Medication Ratio* measure for the entire MCP (a 93.5 percent compliance rate). The number of non-compliant members was 178. Out of the 178 non-compliant members, 80 were noted to need one more refill of their controller medication to close the gap. ■ Utilizing a script, calls were then placed on November 4, 2019, and ended on November 8, 2019. The charts of those who were successfully engaged were reviewed afterwards to determine if a prescription activity occurred after the calls were made. The intervention did not yield the number of controller medication refills that was predicted because reminder calls were only successfully made to a handful of members. Had there been more successful reminder calls, the chances of meeting the goal would have been higher considering the reminder calls generated a 52 percent success rate when compared to the total number of successful calls that resulted in a refill activity. For future call campaigns, HPSJ will work with its member engagement vendor who historically has yielded higher call reach rates.

2018–19 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
2. Determine whether current strategies need to be modified or expanded to improve the rate for the *Comprehensive Diabetes Care—HbA1c Testing* measure in San Joaquin County to above the minimum performance level. (The rate for this measure has been below the minimum performance level for more than three consecutive years in this reporting unit.)	HPSJ consistently held outbound call campaigns to members with gaps in care. The goal of the outbound calls was to help identify lab locations and create access to transportation. HPSJ offered member and provider incentives to close gaps in care. HPSJ continued to outreach to members, offering needed assistance and incentives to close gaps in care. COVID-19 shut down labs and nearly all transportation options available to members beginning in March 2020. In addition, COVID-19 impacted medical record review because HPSJ was unable to pursue secondary chases because provider offices were severely limiting any non-patient care. HPSJ partnered with several provider groups to implement the following interventions: ♦ **Standing Orders**—HPSJ provider partners have devised strategies to improve their performance in the care of patients with diabetes and implemented an internal standing order set/protocol that guides each site/provider to render all diabetes preventive services in one visit. The protocol includes the following: ■ **HbA1c Testing**—Point-of-care testing was done on the day of the visit. ■ **Medical Attention for Nephropathy**—Diabetes patients are required to give urine samples for nephropathy testing. Specimens were picked up by Quest Diagnostics daily. Lab orders were electronically sent. ■ **Blood pressure reading**—Basic to all visits. ■ **Retinal testing**—Referrals were given for retinal testing if due/indicated. Golden Valley Health Centers also started utilizing the HPSJ-sponsored mobile retinal camera by the second quarter of 2019,

2018–19 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	which allowed prompt and better monitoring of diabetic retinal testing among its eligible population. ■ **Diabetic Foot Care** ■ **Nurse Visit**—for weight and nutrition counseling. ♦ **San Joaquin General Hospital**—The county hospital clinics also flag their members who receive a diagnosis of diabetes in their electronic medical record. Once identified, the members are referred to their titration clinic that has dedicated providers and diabetes coaches who follow up on members for testing and diabetes education and counseling. The provider continued to send POC [point of care] data to HPSJ as supplemental data. ♦ **Quest Diagnostics Partnership**—One FQHC revisited its contract with Quest Diagnostics to allow lab specimen pick-up by Quest Diagnostics from all sites. This enabled the FQHC to ensure nephropathy testing from all diabetic visits through urine sample collection during POC rather than sending patients for outside lab testing. ♦ **Diabetes Clinic**—A project intended especially for the evaluation, management, and follow-up of diabetes patients. The provider worked with HPSJ in procuring a retinal test camera. The provider also worked progressively on a contract agreement for supervision of the provider's current diabetes specialist. Although this project was still in the works, the provider is set to get this project operational starting early 2020. ♦ **Retinopathy Clinics**—Retinopathy photos were taken for Golden Valley Health Centers patients either in the mobile retinopathy van or at West Modesto Clinic in Stanislaus

2018–19 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	County. While in-house retinopathy services were provided for the members in the other San Joaquin County clinics, specifically for San Joaquin General Hospital, Human Services Agency, and Community Medical Center. HPSJ also provided some offices with eye cameras to increase members' access to the retinopathy screening. The reading was done internally or sent out to UC Berkeley for interpretation.

Assessment of MCP's Self-Reported Actions

HSAG reviewed HPSJ's self-reported actions in Table 7.1 and determined that HPSJ adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. HPSJ described in detail actions taken during the review period, results from the MCP's assessment of declining performance, how the MCP worked with partners, and steps the MCP plans to take moving forward. Additionally, HPSJ described specific interventions it implemented to improve performance to above the minimum performance levels or prevent further decline in performance and how COVID-19 affected the MCP's quality improvement efforts.

2019–20 Recommendations

Based on the overall assessment of HPSJ's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Monitor the adapted interventions to achieve optimal outcomes beyond the life of the 2017–19 *Cervical Cancer Screening* Disparity PIP.
- Apply lessons learned from the 2017–19 PIPs to strengthen future quality improvement efforts.

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

Medi-Cal Managed Care External Quality Review Technical Report

Appendix S: Performance Evaluation Report Health Plan of San Mateo

July 1, 2019–June 30, 2020

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Table 8.1—HPSM's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report S-26

1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Health Plan of San Mateo ("HPSM" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in HPSM's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

HPSM is a full-scope MCP delivering services to its members in the County Organized Health System model.

HPSM became operational to provide MCMC services in San Mateo County effective December 1987. As of June 2020, HPSM had 104,829 members in San Mateo County.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for HPSM.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of HPSM. A&I conducted the audits from November 4, 2019, through November 14, 2019. A&I assessed HPSM's compliance with its DHCS contract and determined to what extent the MCP had implemented its corrective action plan (CAP) from the October 2018 Medical and State Supported Services Audits.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of HPSM
Audit Review Period: November 1, 2018, through October 31, 2019

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

Follow-Up on 2017 and 2018 A&I Medical and State Supported Services Audits

A&I conducted Medical and State Supported Services Audits of HPSM from November 27, 2017, through December 8, 2017 (covering the review period of November 1, 2016, through October 31, 2017), and from October 9, 2018, through October 19, 2018 (covering the period November 1, 2017, through September 30, 2018). HSAG provided a summary of the audit results and status in HPSM's 2017–18 and 2018–19 MCP-specific evaluation reports. At the time these evaluation reports were published, HPSM's CAPs for the 2017 and 2018 audits were in progress and under review by DHCS. Final closeout letters from DHCS, both dated November 3, 2020, stated that HPSM provided DHCS with additional information regarding the CAPs, and that DHCS had reviewed the information and closed both the 2017 and 2018 CAPs. While the final closeout letters were sent to the MCP outside the review dates for this report, HSAG includes the information from the letters because they reflect full resolution of the findings from the 2017 and 2018 audits.

Strengths—Compliance Reviews

A&I identified no findings in the State Supported Services category during the November 2019 Medical and State Supported Services Audits of HPSM. Additionally, HPSM submitted documentation to DHCS that resolved all findings from the 2017 and 2018 A&I Medical and State Supported Services Audits and resulted in DHCS closing the CAPs.

Opportunities for Improvement—Compliance Reviews

HPSM has the opportunity to work with DHCS to fully resolve the findings from the 2019 A&I Medical and State Supported Services Audits. During the 2019 Medical Audit, A&I identified repeat findings in the Access and Availability of Care and Quality Management categories. HPSM should thoroughly review all findings and implement the actions recommended by A&I.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures HPSM chose to report using one or both of these two options.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- ♦ Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- ♦ Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of HPSM, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Health Plan of San Mateo* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for HPSM's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
HPSM—San Mateo County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	53.28%
Childhood Immunization Status—Combination 10	51.58%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	96.84%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	89.04%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	92.68%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	89.66%

Measure	Reporting Year 2020 Rate
Developmental Screening in the First Three Years of Life—Total	45.28%
Immunizations for Adolescents—Combination 2	55.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	73.97%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	48.18%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.64%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
HPSM—San Mateo County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	65.86%
Cervical Cancer Screening	70.10%
Chlamydia Screening in Women—Ages 16–20 Years	64.49%
Chlamydia Screening in Women—Ages 21–24 Years	72.37%
Chlamydia Screening in Women—Total	67.49%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	17.88%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	27.70%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	3.58%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.98%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	15.79%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	15.79%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	47.37%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	41.84%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	6.97%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	31.58%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	21.84%
Prenatal and Postpartum Care—Postpartum Care	84.18%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.59%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
HPSM—San Mateo County

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

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	67.02%

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	49.37%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	22.70%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	23.85%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	28.69%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	25.26%

Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
HPSM—San Mateo County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	85.16%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	49.88
Asthma Medication Ratio—Total	61.35%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	30.17%

Measure	Reporting Year 2020 Rate
Comprehensive Diabetes Care—HbA1c Testing—Total	91.24%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	19.95%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	15.04%
Controlling High Blood Pressure—Total	65.69%
HIV Viral Load Suppression—Ages 18–64 Years	48.39%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.37%
Plan All-Cause Readmissions—Expected Readmissions—Total	10.45%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.99
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	12.44%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	5.07%

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, HPSM will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations HPSM—San Mateo County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	63.12	47.64	Not Tested	49.88
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	96.83%	Not Comparable	96.84%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	91.06%	89.01%	2.05	89.04%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	86.07%	92.84%	-6.77	92.68%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	89.05%	89.68%	-0.63	89.66%
*Plan All-Cause Readmissions— Total***	12.39%	9.86%	2.53	10.37%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that HPSM stratified by the SPD and non-SPD populations and for which HSAG could compare reporting year 2020 SPD rates to reporting year 2020 non-SPD rates, HSAG noted that members ages 7 to 11 years in the SPD population had significantly fewer instances of a visit with a primary care provider (PCP) during the measurement year than members in this age group in the non-SPD population in reporting year 2020. The significant difference may be attributed to the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from PCPs.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to HPSM's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that HPSM report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the reporting year 2020 rates for each required MLTSSP performance measure. Table 4.1 presents reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 4.1—Reporting Year 2020 MLTSSP Performance Measure Results HPSM—San Mateo County

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	79.02
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.84%
Plan All-Cause Readmissions—Expected Readmissions—Total	12.68%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.93

5. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, HPSM submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, HPSM initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

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

Table 5.1 provides the SMART Aim measure results reported by the MCP for its *Cervical Cancer Screening* Disparity PIP.

Table 5.1—HPSM *Cervical Cancer Screening* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of cervical cancer screening among members with an English language preference, ages 24 to 64, and assigned to Provider A[6]	56.7%	67.4%	No

[6] Provider name removed for confidentiality.

Table 5.2 presents a description of the intervention that HPSM tested for its *Cervical Cancer Screening* Disparity PIP. The table also indicates the failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.2—HPSM *Cervical Cancer Screening* Disparity PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Outreach to women who are due for a cervical cancer screening and have not been to Provider A for a primary care visit either 1) in the last 12 months or 2) since their assignment to Provider A membership panel	♦ Women do not meet Provider A's criteria of having a prior PCP visit in the past 12 months for targeted cervical cancer screening outreach ♦ Women not scheduled for a primary care visit since being assigned to Provider A	Abandon

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for HPSM's *Cervical Cancer Screening* Disparity PIP. In the modules, HPSM documented that it tested the member outreach intervention from January 2019 through June 2019. The MCP determined that a large portion of members outreached were unable to be contacted and only a small portion of members completed their cervical cancer screening. HPSM did not achieve the SMART Aim goal and chose to abandon the intervention.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned HPSM's *Cervical Cancer Screening* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Due to HPSM demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. Based on its MCP-specific data, HPSM selected asthma medication ratio as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure results as reported by the MCP for its *Asthma Medication Ratio* PIP.

Table 5.3—HPSM *Asthma Medication Ratio* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of asthma medication ratio of 0.50 or greater for the rolling 12-month lookback period among members ages 19 to 50 living with persistent asthma	60.0%	71.0%	No

Table 5.4 presents a description of the intervention that HPSM tested for its *Asthma Medication Ratio* PIP. The table also indicates the key drivers and failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.4—HPSM *Asthma Medication Ratio* PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Pilot asthma outreach to targeted members ages 19 to 50 years who are not compliant with the *Asthma Medication Ratio* measure specification	♦ Members' knowledge ♦ Members' perception ♦ Continued use of controller medications ♦ Members forget to refill their controller medications ♦ Members are not motivated to refill their controller medications despite awareness of the importance of controller medication adherence ♦ Members are unaware or forget that controller medications are available for pick-up at a pharmacy ♦ Members do not pick up controller medications from a pharmacy despite awareness of prescriptions being ordered	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for HPSM's *Asthma Medication Ratio* PIP. In the modules, HPSM documented that it tested the telephonic outreach intervention from November 2018 through June 2019 to target members who were non-compliant with the *Asthma Medication Ratio* specification. The MCP determined that the outreach intervention did not impact the SMART Aim rate and planned to adapt the intervention by exploring other communication modes, such as text messages.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned HPSM's *Asthma Medication Ratio* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, HPSM identified cervical cancer screening among members living with disabilities as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Cervical Cancer Screening* Health Equity PIP. HPSM met all Module 1 validation criteria in its initial submission. Upon initial review of Module 2, HSAG determined that HPSM met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Labeling clearly the identified gaps or opportunities for improvement in the process map steps.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Linking logically the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.
- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.

After receiving technical assistance from HSAG, HPSM incorporated HSAG's feedback into Module 2. Upon final review, HSAG determined that the MCP met all validation criteria for Module 2. HPSM was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, HPSM selected adolescent well-care visits as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated Module 1 for the MCP's *Adolescent Well-Care Visit* PIP. Upon initial review of the module, HSAG determined that HPSM met some required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of the SMART Aim statement and SMART Aim data collection methodology. After receiving technical assistance from HSAG, HPSM incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. HPSM was in the process of working on its Module 2 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 *Asthma Medication Ratio* PIP, HPSM identified an intervention that it can adapt to improve the asthma medication ratio among members living with persistent asthma.

Opportunities for Improvement—Performance Improvement Projects

HPSM has the opportunity to monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Asthma Medication Ratio* PIP. The MCP should also apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adapted intervention and to strengthen future quality improvement efforts.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs’ call centers are meeting DHCS’ 10-minute wait time standard and the call centers’ knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

HPSM submitted the MCP's PNA report to DHCS on August 25, 2020, and DHCS notified the MCP via email on September 8, 2020, that DHCS approved the report as submitted. While HPSM submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from HPSM's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of HPSM's self-reported actions.

Table 8.1—HPSM's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP resolves all findings from the 2017 A&I Medical Audit and 2018 A&I Medical and State Supported Services Audits.	HPSM has submitted formal CAP responses for all identified deficiencies to DHCS. HPSM continues to communicate with DHCS regarding corrective actions that are in progress, had prospective compliance dates, or were identified as repeat issues in the subsequent 2019 A&I Medical Audit.

Assessment of MCP's Self-Reported Actions

HSAG reviewed HPSM's self-reported actions in Table 8.1 and determined that HPSM adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. At the time HPSM submitted its self-reported actions, the MCP noted that it was actively working with DHCS to fully resolve the findings from the 2017 and 2018 A&I Medical and State Supported Services Audits. Subsequently, all findings from the 2017 and 2018 audits were resolved and DHCS closed the corresponding CAPs.

2019–20 Recommendations

Based on the overall assessment of HPSM's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- ♦ Work with DHCS to fully resolve the findings from the 2019 A&I Medical and State Supported Services Audits. HPSM should thoroughly review all findings and implement the actions recommended by A&I.
- ♦ Monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Asthma Medication Ratio* PIP.
- ♦ Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the adapted intervention and to strengthen future quality improvement efforts.

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

Medi-Cal Managed Care External Quality Review Technical Report

Appendix T: Performance Evaluation Report Inland Empire Health Plan

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Inland Empire Health Plan ("IEHP" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in IEHP's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

IEHP is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in IEHP, the Local Initiative MCP, or in Molina Healthcare of California Partner Plan, Inc., the alternative commercial plan.

IEHP became operational in Riverside and San Bernardino counties to provide MCMC services effective 1996. As of June 2020, IEHP had 627,160 members in Riverside County and 622,723 in San Bernardino County—for a total of 1,249,883 members.[1] This represents 88 percent of the beneficiaries enrolled in Riverside County and 90 percent in San Bernardino County.

DHCS allows IEHP to combine data for Riverside and San Bernardino counties for reporting purposes. For this report, Riverside and San Bernardino counties represent a single reporting unit.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for IEHP. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of IEHP. A&I conducted the audits from October 7, 2019, through October 11, 2019.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of IEHP
Audit Review Period: October 1, 2018, through September 30, 2019

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

Strengths—Compliance Reviews

A&I identified no findings in the Utilization Management, Quality Management, Administrative and Organizational Capacity, and State Supported Services categories during the October 2019 Medical and State Supported Services Audits of IEHP. Additionally, in response to the CAP from the October 2019 audits, IEHP submitted documentation to DHCS that resulted in DHCS closing the CAP. IEHP's documentation reflected changes to policies and procedures to ensure:

- Continuity of care approval letters contain all required information.
- The MCP monitors waiting times for providers to answer and return members' telephone calls.
- Members are notified of their grievance status and estimated completion date when resolution is not reached within 30 calendar days.

Opportunities for Improvement—Compliance Reviews

IEHP has no outstanding findings from the October 2019 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures IEHP chose to report using one or both of these two options.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of IEHP, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Inland Empire Health Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that IEHP followed the appropriate specifications to produce valid rates; however, during final rate review, the auditor identified an encounter data file that was incorrectly incorporated into the MCP's reporting software as supplemental data. Upon investigation, it was determined that overall, the misclassified encounter data constituted less than 1 percent of the total encounter data files. While the impact appeared to be minimal, IEHP should implement oversight processes to ensure that all data files are accurately mapped prior to the data being uploaded for HEDIS reporting.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for IEHP's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
IEHP—Riverside/San Bernardino Counties

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	48.91%
Childhood Immunization Status—Combination 10	31.14%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	93.47%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	86.21%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	86.58%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	85.02%

Measure	Reporting Year 2020 Rate
Developmental Screening in the First Three Years of Life—Total	12.92%
Immunizations for Adolescents—Combination 2	39.42%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	89.54%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	49.88%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.94%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
IEHP—Riverside/San Bernardino Counties

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	65.15%
Cervical Cancer Screening	70.07%
Chlamydia Screening in Women—Ages 16–20 Years	60.22%
Chlamydia Screening in Women—Ages 21–24 Years	69.83%
Chlamydia Screening in Women—Total	65.03%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	15.82%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	26.59%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.68%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.30%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	2.79%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	10.34%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	37.47%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	39.69%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	1.23%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.11%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	14.58%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	10.88%
Prenatal and Postpartum Care—Postpartum Care	77.13%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	92.94%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
IEHP—Riverside/San Bernardino Counties

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	58.56%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	39.95%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	34.32%

Measure	Reporting Year 2020 Rate
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	44.03%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	36.90%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	26.14%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	31.50%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
IEHP—Riverside/San Bernardino Counties

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	88.32%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	46.41
Asthma Medication Ratio—Total	55.10%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	32.36%
Comprehensive Diabetes Care—HbA1c Testing—Total	89.05%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	13.42%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	12.28%

Measure	Reporting Year 2020 Rate
Controlling High Blood Pressure—Total	60.58%
HIV Viral Load Suppression—Ages 18–64 Years	16.76%
HIV Viral Load Suppression—Ages 65+ Years	23.33%
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.02%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.54%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.84
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.36%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	3.48%

Assessment of Improvement Plan—Acute and Chronic Disease Management Domain

In April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that IEHP conducted as part of its IP prior to April 2020.

Based on reporting year 2019 performance measure results, DHCS required IEHP to submit an IP for the *Asthma Medication Ratio—Total* measure. IEHP tested whether conducting provider outreach to obtain commitment to receive training from at least four providers who were not appropriately prescribing asthma medications would improve the *Asthma Medication Ratio—Total* measure rate in Riverside/San Bernardino counties. IEHP conducted face-to-face asthma-related academic detailing training with individual providers. The MCP indicated learning the following:

- It was helpful to use a shared, existing, modifiable provider outreach log to capture the details of the provider outreach.
- Holding daily academic detailing team huddles was effective for sharing barriers and issues and obtaining management guidance and input in a timely manner.
- It was time efficient to send written outreach communication via email blast-faxes or mailed letters.

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of IEHP's performance related to the *Asthma Medication Ratio—Total* measure.

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, IEHP will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations IEHP—Riverside/San Bernardino Counties

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	72.72	44.61	Not Tested	46.41
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	94.27%	93.46%	0.81	93.47%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	88.85%	86.17%	2.68	86.21%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	88.99%	86.51%	2.48	86.58%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	85.77%	85.00%	0.77	85.02%
*Plan All-Cause Readmissions—Total***	9.97%	7.48%	2.49	8.02%

Seniors and Persons with Disabilities—Performance Measure Findings

HSAG observed the following notable results in reporting year 2020 for measures that IEHP stratified by the SPD and non-SPD populations:

- The reporting year 2020 SPD rates were significantly better than the reporting year 2020 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years* and *7–11 Years* measures.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that IEHP followed the appropriate specifications to produce valid rates.

Opportunities for Improvement—Performance Measures

IEHP has the opportunity to implement oversight processes to ensure that all data files are accurately mapped prior to the data being uploaded for HEDIS performance measure rate reporting.

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to IEHP's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that IEHP report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the reporting year 2020 rates for each required MLTSSP performance measure. Table 4.1 presents reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 4.1—Reporting Year 2020 MLTSSP Performance Measure Results
IEHP—Riverside/San Bernardino Counties

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	47.08
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.26%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.67%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.75

5. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, IEHP submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, IEHP initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

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

Table 5.1 provides the SMART Aim measure results reported by the MCP for its *Childhood Immunization Status—Combination 10* Disparity PIP.

Table 5.1—IEHP *Childhood Immunization Status—Combination 10* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of the *Childhood Immunization Status—Combination 10* measure among members who identify as Black residing in the Riverside Region	7.64%	15.98%	No

Table 5.2 presents a description of the intervention that IEHP tested for its *Childhood Immunization Status—Combination 10* Disparity PIP. The table also indicates the key drivers and failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.2—IEHP *Childhood Immunization Status—Combination 10* Disparity PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Conduct home visits to members' caregivers to provide culturally appropriate education on immunizations and promote adherence	♦ Members' awareness and education ♦ Members' caregivers are not provided with culturally appropriate information about the importance of immunizations ♦ Members' caregivers do not review educational materials provided ♦ Members' caregivers are unaware of the immunization schedule ♦ Members' caregivers struggle to follow the immunization schedule ♦ Members' caregivers do not perceive immunizations as necessary to maintain members' health ♦ Members' caregivers perceive immunizations as harmful to members	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for IEHP's *Childhood Immunization Status—Combination 10* Disparity PIP. IEHP documented in the modules that it tested the home visit intervention from December 2018 through June 2019. The MCP reported that it was unable to contact almost half of the outreached members. IEHP concluded that the home visits do not impact members receiving immunizations; however, they are successful in providing education on the immunization schedule. The MCP decided to adapt the intervention by having the home visiting health navigators scan the member immunization cards during the home visits.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned IEHP's *Childhood Immunization Status—Combination 10* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Due to IEHP demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. Based on its MCP-specific data, IEHP selected asthma medication ratio as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure results as reported by the MCP for its *Asthma Medication Ratio* PIP.

Table 5.3—IEHP *Asthma Medication Ratio* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of the *Asthma Medication Ratio* measure among members ages 5 to 65 years with persistent asthma who are assigned to partnering providers	23.18%	33.47%	Yes

Table 5.4 presents a description of the intervention that IEHP tested for its *Asthma Medication Ratio* PIP. The table also indicates the key drivers and failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.4—IEHP *Asthma Medication Ratio* PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Partner with a vendor that conducts targeted provider education and support in managing the asthma population; and conduct member outreach to educate members on asthma medication management	♦ Provider awareness and education of clinical pathways and population management strategies for asthma care management ♦ Members' awareness and education of asthma self-management through an asthma action plan	Adapt

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
	♦ Development of a key asthma management intervention in partnership with a vendor ♦ Provider is unable to identify members with persistent asthma who are in need of an Asthma Action Plan ♦ Provider does not have sufficient time or resources to monitor or review asthma medications ♦ Members are unaware of or do not understand the Asthma Action Plan ♦ Provider does not develop an Asthma Action Plan with members during visits ♦ Provider does not actively manage members' asthma conditions	

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for IEHP's *Asthma Medication Ratio* PIP. In the modules, IEHP documented that it tested partnering with a vendor that worked with nine targeted providers to conduct provider training and provide support in managing members living with asthma, as well as to conduct member outreach to educate members on asthma medication management. The MCP surpassed the SMART Aim goal and achieved the highest monthly SMART Aim rate of 52.52 percent in June 2019.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned IEHP's *Asthma Medication Ratio* PIP a final confidence level of *High Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, IEHP identified adolescent well-care visits as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 through 3 for the MCP's *Adolescent Well-Care Visits* Health Equity PIP. Upon initial review of the modules, HSAG determined that IEHP met all Module 2 validation criteria in its initial submission; however, HSAG identified opportunities for improvement related to the following validation criteria for modules 1 and 3:

- Including all required components of the SMART Aim data collection methodology.
- Including all required components of the SMART Aim run chart.
- Including all required components of the Intervention Plan.
- Ensuring that the intervention effectiveness measure was appropriate for the intervention.
- Ensuring that the data collection process was appropriate for the intervention effectiveness measure.

After receiving technical assistance from HSAG, IEHP incorporated HSAG's feedback into modules 1 and 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 3.

Table 5.5 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the MCP's *Adolescent Well-Care Visits* Health Equity PIP.

Table 5.5—IEHP *Adolescent Well-Care Visits* Health Equity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of well-care visits among members 17 to 21 years of age residing in the city of Victorville	17.81%	55.00%

Table 5.6 presents a description of the intervention that IEHP selected to test for its *Adolescent Well-Care Visits* Health Equity PIP. The table also indicates the key driver and failure mode that the intervention aims to address.

Table 5.6—IEHP *Adolescent Well-Care Visits* Health Equity PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Implement member incentive program to award members a $25 Walmart gift card for completing their annual adolescent well-care visits	♦ Members fail to attend to their well-care visits ♦ Members' education and awareness

While IEHP advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, IEHP selected well-child visits in the first 15 months of life as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits in the First 15 Months of Life* PIP. Upon initial review of the modules, HSAG determined that IEHP met some Module 1 required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.
- Including all required components of the SMART Aim run chart.

After receiving technical assistance from HSAG, IEHP incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. IEHP met all Module 2 validation criteria in its initial submission, and the MCP was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

IEHP achieved the SMART Aim goal for the 2017–19 *Asthma Medication Ratio* PIP, and all of the quality improvement activities could be linked to the demonstrated improvement. Based on its assessment, HSAG assigned the 2017–19 *Asthma Medication Ratio* PIP a final confidence level of *High Confidence.* Additionally, upon completion of the 2017–19 PIPs, IEHP identified interventions that it can adapt to improve immunization compliance among children younger than 2 years of age as well as asthma medication among members living with persistent asthma.

Opportunities for Improvement—Performance Improvement Projects

IEHP has the opportunity to monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 10* Disparity PIP. Additionally, the MCP has the opportunity to continue monitoring the adapted intervention and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Asthma Medication Ratio* PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 (“Validation of Network Adequacy”) provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS’ process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

IEHP submitted the MCP's PNA report to DHCS on June 25, 2020, and DHCS notified the MCP via email on July 6, 2020, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from IEHP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of IEHP's self-reported actions.

Table 8.1—IEHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Identify the causes for the *Asthma Medication Ratio* measure rate being below the minimum performance level for reporting year 2019 and develop strategies, as applicable, to ensure that beneficiaries ages 5 to 64 who are identified as having persistent asthma have a ratio of controller medications to total asthma medications of 0.50 or greater.	IEHP's *Asthma Medication Ratio* measure rate in 2018 fell below the minimum performance level for measurement year 2018. From 2017 to 2019, IEHP worked on an *Asthma Medication Ratio* PIP to identify failure modes contributing to low controller medication adherence. At the conclusion of this project, IEHP determined that provider education and academic detailing have a positive impact on utilization of controller medications among members with persistent asthma as opposed to dependence on rescue medications. IEHP's quality and pharmacy teams worked together to adapt the PIP intervention to continue improving the *Asthma Medication Ratio* measure rate. IEHP developed an academic detailing program with the goal of improving primary care providers' ability to identify and care for their assigned member population with persistent asthma.

2018–19 External Quality Review Recommendations Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	Barriers Identified: ♦ Available resources which allow the provider to identify members with persistent asthma are limited. ♦ Members may have limited resources or barriers to lifestyle changes to adhere to the Asthma Action Plan. ♦ Provider may have limited resources to develop the Asthma Action Plan. ♦ Provider may have limited resources for monitoring members' progression on the Asthma Action Plan during follow-up visits. **IEHP Interventions Taken:** ♦ In November 2019, IEHP's pharmacy team established an academic detailing curriculum for visits with providers identified as having a low *Asthma Medication Ratio* compliance rate. During these visits, pharmacy technicians provided member rosters with the ratio of controller medication details, member contact information, and pharmacy claims related to asthma medications. ♦ Providers received a pocket guide of asthma formulary medications for quick reference, a sample Asthma Action Plan, and educational resources for member distribution. To support providers' focus on providing safe and effective patient care during the COVID-19 pandemic, the academic detailing visits remain on hold at this time.

Assessment of MCP's Self-Reported Actions

HSAG reviewed IEHP's self-reported actions in Table 8.1 and determined that IEHP adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. IEHP described in detail barriers the MCP identified. IEHP also described interventions the MCP implemented to improve performance for this measure to above the minimum performance level, including adapting the academic detailing intervention from the 2017–19 *Asthma Medication Ratio* PIP.

2019–20 Recommendations

Based on the overall assessment of IEHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- ♦ Implement oversight processes to ensure that all data files are accurately mapped prior to the data being uploaded for HEDIS performance measure rate reporting.
- ♦ Monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 10* Disparity PIP.
- ♦ Continue monitoring the adapted intervention and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Asthma Medication Ratio* PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.

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

Medi-Cal Managed Care External Quality Review Technical Report

Appendix U: Performance Evaluation Report Kaiser NorCal (KP Cal, LLC, in Amador, El Dorado, Placer, and Sacramento Counties)

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, KP Cal, LLC, in Amador, El Dorado, Placer, and Sacramento counties (commonly known as "Kaiser Permanente North" and referred to in this report as "Kaiser NorCal" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in Kaiser NorCal's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its

requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

Kaiser NorCal is a full-scope MCP delivering services to its members under two health care models—the Geographic Managed Care (GMC) model and the Regional model.

Although the GMC model operates in the counties of San Diego and Sacramento, Kaiser NorCal only operates in Sacramento County. In the GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county). In addition to Kaiser NorCal, Sacramento County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
- Health Net Community Solutions, Inc.
- Molina Healthcare of California

In Amador, El Dorado, and Placer counties, Kaiser NorCal delivers services to its members under the Regional model. In all three counties, beneficiaries may enroll in Kaiser NorCal or in Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan or California Health & Wellness Plan, the other commercial plans.

Kaiser NorCal became operational in Sacramento County to provide MCMC services effective April 1994. As part of MCMC's expansion under Section 1115 of the Social Security Act, Kaiser NorCal contracted with DHCS to provide MCMC services in Amador, El Dorado, and Placer counties beginning November 1, 2013. As of June 2020, Kaiser NorCal had 89,791 members in Sacramento County, 118 in Amador County, 2,190 in El Dorado County, and 8,504 in Placer County.[1] This represents 21 percent of the beneficiaries enrolled in Sacramento County, 2 percent in Amador County, 8 percent in El Dorado County, and 18 percent in Placer County.

DHCS allows Kaiser NorCal to combine the data from Sacramento, Amador, El Dorado, and Placer counties for reporting purposes. For this report, these four counties are considered a single reporting unit (KP North).

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Kaiser NorCal. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Kaiser NorCal. A&I conducted the audits from September 30, 2019, through October 11, 2019. A&I assessed Kaiser NorCal's compliance with its DHCS contract and determined to what extent the MCP had implemented its CAP from the 2018 Medical Audit. Note that the CAP from the 2018 audit is still open.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Kaiser NorCal Audit Review Period: September 1, 2018, through August 31, 2019

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

Follow-Up on 2017 Medical Audit

A&I conducted a Medical Audit of Kaiser NorCal in October 2017. HSAG provided a summary of the audit results and status in Kaiser NorCal's 2017–18 and 2018–19 MCP-specific evaluation reports. At the time of both reports' publication, Kaiser NorCal's CAP was in process and under review by DHCS. A letter dated March 5, 2020, stated that Kaiser NorCal provided DHCS with additional information regarding the CAP, and that DHCS had reviewed the information and closed the CAP. The letter indicated that DHCS would monitor the MCP's full implementation of the CAP during the subsequent audit.

Strengths—Compliance Reviews

A&I identified no findings in the State Supported Services category during the 2019 Medical and State Supported Services Audits of Kaiser NorCal. Additionally, in response to the CAP from the October 2017 A&I Medical Audit, Kaiser NorCal submitted documentation to DHCS regarding the actions the MCP took to resolve the findings DHCS identified during the audit. Kaiser NorCal's documentation resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

Kaiser NorCal has the opportunity to work with DHCS to fully resolve the findings from the 2018 and 2019 A&I Medical Audits. During the 2019 Medical Audit, A&I identified repeat findings in the Utilization Management, Access and Availability of Care, Member's Rights, and Quality Management categories. Kaiser NorCal should thoroughly review all findings and implement the actions recommended by A&I.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Kaiser NorCal uses KP Health Connect, an electronic health record system, which allows providers to enter service information directly into the system, resulting in a higher degree of data capture and completeness. As a result, DHCS allows the MCP to report all MCAS measures using the administrative method.

[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of Kaiser NorCal, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Kaiser NorCal* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for Kaiser NorCal's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Kaiser NorCal—KP North

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	53.50%
Childhood Immunization Status—Combination 10	54.72%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	98.26%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	87.32%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	88.88%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	90.31%
Developmental Screening in the First Three Years of Life—Total	79.17%
Immunizations for Adolescents—Combination 2	68.87%

Measure	Reporting Year 2020 Rate
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	89.18%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	81.38%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.38%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Kaiser NorCal—KP North

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	82.19%
Cervical Cancer Screening	87.44%
Chlamydia Screening in Women—Ages 16–20 Years	67.35%
Chlamydia Screening in Women—Ages 21–24 Years	75.80%
Chlamydia Screening in Women—Total	71.18%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	24.21%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.55%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	4.67%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.29%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	19.10%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	17.24%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	52.81%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	41.19%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	5.95%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	25.84%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	16.48%
Prenatal and Postpartum Care—Postpartum Care	82.45%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	96.46%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Kaiser NorCal—KP North

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	69.25%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	49.84%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	48.60%

Measure	Reporting Year 2020 Rate
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	58.82%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.31%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	27.29%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	17.05%

Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Kaiser NorCal—KP North

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	97.27%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	45.97
Asthma Medication Ratio—Total	87.80%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	24.84%
Comprehensive Diabetes Care—HbA1c Testing—Total	94.44%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	9.49%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	8.03%

Measure	Reporting Year 2020 Rate
Controlling High Blood Pressure—Total	77.89%
HIV Viral Load Suppression—Ages 18–64 Years	94.23%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.40%
Plan All-Cause Readmissions—Expected Readmissions—Total	8.64%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.20
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.76%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	3.32%

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, Kaiser NorCal will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Kaiser NorCal—KP North

[green] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

[red] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	70.19	42.53	Not Tested	45.97
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	98.25%	Not Comparable	98.26%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	96.35%	87.06%	9.29	87.32%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	96.56%	88.53%	8.03	88.88%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	93.28%	90.19%	3.09	90.31%
*Plan All-Cause Readmissions— Total***	12.58%	9.62%	2.96	10.40%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that Kaiser NorCal stratified by the SPD and non-SPD populations and for which HSAG could make a comparison between the reporting year 2020 SPD rate and reporting year 2020 non-SPD rate, the SPD rates were significantly better than the non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years*, *Ages 7–11 Years*, and *Ages 12–19 Years* measures.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, Kaiser NorCal submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, Kaiser NorCal initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, Kaiser NorCal identified contraception use among adolescents in South Sacramento as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure results reported by the MCP for its *Contraception* Disparity PIP.

Table 4.1—Kaiser NorCal *Contraception* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of most to moderately effective forms of contraception use among members ages 12 to 18 who have had a chlamydia test and who have a pediatrician in the South Sacramento service area	68.35%	73.40%	Yes

Table 4.2 presents a description of the interventions that Kaiser NorCal tested for its *Contraception* Disparity PIP. The table also indicates the key drivers and failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—Kaiser NorCal *Contraception* Disparity PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Develop a clear and consistent birth control counseling workflow and conduct training for nurses	♦ Support staff training ♦ Contraception counseling does not occur	Adopt
Provide contraception counseling during adolescent routine well-visit appointment outreach calls	♦ Adolescent due for well-child visit	Adapt
Establish a process for doctors to make referrals to nurses to follow up on sexually active teens not using birth control to provide birth control counseling over the phone	♦ Follow-up calls to sexually active teens who are seen in the clinic but do not select contraception	Adopt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Kaiser NorCal's *Contraception* Disparity PIP. Kaiser NorCal documented in the modules that it tested three interventions to increase the use of contraception among adolescents in the South Sacramento service area. From October 2018 through June 2019, Kaiser NorCal tested the standardization of contraception counseling workflow and nurse training intervention. The MCP determined that the standard workflow and the training helped staff members feel more comfortable providing contraception information to members. Thus, Kaiser NorCal decided to adopt the intervention to continue to refine the workflow as well as to train staff members about the workflow.

Kaiser NorCal also tested the impact of providing contraception counseling during member outreach calls when appropriate. The MCP tested this intervention from January 2019 through May 2019 and conducted the outreach to adolescent members identified as sexually active and not on birth control. While only 25 percent of the members who attended the well visit began using birth control, Kaiser NorCal determined that the intervention had a small cohort and was moving in the right direction. Thus, the MCP decided to adapt the intervention to conduct outreach to adolescent members who are due for routine well-care visits.

Lastly, from February 2019 through May 2019, Kaiser NorCal tested a new process for doctors to make referrals for nurses to provide telephonic contraception counseling to sexually active adolescent members who were not on birth control. The MCP's intervention evaluation determined that the intervention yielded a high number of referrals and ultimately increased

contraception use among those outreached members. Thus, Kaiser NorCal determined to adopt the intervention.

By the end of the PIP, Kaiser NorCal achieved the SMART Aim goal. The MCP also documented a decrease in disparity in the rate of adolescent contraception use between the South Sacramento and Roseville service areas.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned Kaiser NorCal's *Contraception* Disparity PIP a final confidence level of *Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Due to Kaiser NorCal demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. Based on its MCP-specific data, Kaiser NorCal selected initial health assessments as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure results as reported by the MCP for its *Initial Health Assessment* PIP.

Table 4.3—Kaiser NorCal *Initial Health Assessment* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of initial health assessment (physical exam and health questionnaire) completion among members assigned to Provider A[6]	25.7%	27.5%	Yes

Table 4.4 presents a description of the interventions that Kaiser NorCal tested for its *Initial Health Assessment* PIP. The table also indicates the failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

[6] Provider name removed for confidentiality.

Table 4.4—Kaiser NorCal *Initial Health Assessment* PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Conduct training for providers and medical assistants about MCMC	Lack of knowledge and education among providers and medical assistants about MCMC	Adopt
Conduct training for providers and medical assistants on the initial health assessment coding requirements	Lack of consistent coding by providers and medical assistants for clinic visits	Adopt
Develop and implement SmartPhrase, which documents the resources offered to members as a tool for providers to understand what has already been provided to members, thereby giving providers more time to discuss clinical topics during appointments	Lack of knowledge about what resources are provided to members when a high-priority, positive response is identified in the Medi-Cal Onboarding Questionnaire	Adopt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Kaiser NorCal's *Initial Health Assessment* PIP. Kaiser NorCal documented in the modules that it tested three interventions to improve the rate of the initial health assessment completion. From May 2018 through December 2019, the MCP conducted trainings for providers and medical assistants about MCMC and the initial health assessment requirements. Based on training evaluation survey results, the MCP determined that the trainings were effective and decided to adopt the intervention to conduct additional trainings for staff members regarding MCMC and initial health assessment requirements.

In May 2018 Kaiser NorCal also began testing the effectiveness of conducting trainings for providers and medical assistants on the proper coding requirements for initial health assessments. As a result of the trainings, the MCP noted an increase in the percentage of initial health assessments that were coded correctly; therefore, the MCP adopted the intervention to conduct additional trainings in other Sacramento service areas.

Lastly, from December 2018 through January 2019, Kaiser NorCal developed and tested SmartPhrase, which is a tool that tracks the resources the member engagement specialists offer to members. The goal of SmartPhrase is to allow providers to more easily know the resources that the members have already been provided to allow providers more time to discuss clinical topics and complete the initial health assessments. After two months of testing

the tool and based on provider survey results, Kaiser NorCal concluded that SmartPhrase was useful and decided to adopt the intervention.

Kaiser NorCal indicated that it exceeded the SMART Aim goal for this PIP; however, the MCP did not document the monthly SMART Aim measure numerator and denominator data; therefore, HSAG could not validate the accuracy of the monthly SMART Aim measure rates and whether the improvement in the SMART Aim measure data could be clearly linked to the interventions.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned Kaiser NorCal's *Initial Health Assessment* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, Kaiser NorCal identified hypertension control among African-American members living in South Sacramento as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 through 3 for the MCP's *Hypertension Control* Health Equity PIP. Upon initial review of the modules, HSAG determined that Kaiser NorCal met all Module 2 validation criteria; however, HSAG identified opportunities for improvement related to the following validation criteria for modules 1 and 3:

- Including all required components of the SMART Aim data collection methodology.
- Including all required components of the SMART Aim.
- Ensuring that the intervention effectiveness measure was appropriate for the intervention.
- Ensuring that the data collection process was appropriate for the intervention effectiveness measure.

After receiving technical assistance from HSAG, Kaiser NorCal incorporated HSAG's feedback into modules 1 and 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 3.

Table 4.5 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the MCP's *Hypertension Control* Health Equity PIP.

Table 4.5—Kaiser NorCal *Hypertension Control* Health Equity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of controlled hypertension among African-American members ages 18 to 65 living in South Sacramento	63.6%	74.1%

Table 4.6 presents a description of the intervention that Kaiser NorCal selected to test for its *Hypertension Control* Health Equity PIP. The table also indicates the failure mode that the intervention aims to address.

Table 4.6—Kaiser NorCal *Hypertension Control* Health Equity PIP Intervention Testing

Intervention	Failure Mode Addressed
Provide complex case management to a subset of high-risk hypertensive members with an emphasis on medication management and lifestyle management	Members do not comply with the pharmacist's recommendations on medication management

While Kaiser NorCal advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, Kaiser NorCal selected adolescent well-care visits as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated Module 1 for the MCP's *Adolescent Well-Care Visits* PIP. Upon initial review of the module, HSAG determined that Kaiser NorCal met some required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of the:

- SMART Aim statement.
- SMART Aim data collection methodology.
- SMART Aim run chart.

After receiving technical assistance from HSAG, Kaiser NorCal incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. Kaiser NorCal was in the process of working on its Module 2 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Kaiser NorCal achieved the SMART Aim goal for the 2017–19 *Contraception* Disparity PIP, and some of the quality improvement activities could be linked to the demonstrated improvement. Based on its assessment, HSAG assigned the 2017–19 *Contraception* Disparity PIP a final confidence level of *Confidence*. Additionally, upon completion of the 2017–19 *Contraception* Disparity PIP and the 2017-19 *Initial Health Assessment* PIP, Kaiser NorCal identified interventions that it can adopt and adapt to increase the use of contraception among adolescents as well as to improve initial health assessment completion rates.

Opportunities for Improvement—Performance Improvement Projects

Kaiser NorCal has the opportunity to continue monitoring adopted and adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Contraception* Disparity PIP and *Initial Health Assessment* PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

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

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

Kaiser NorCal submitted the MCP's PNA report to DHCS on June 30, 2020, and DHCS notified the MCP via email on July 24, 2020, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 7.1 provides EQR recommendations from Kaiser NorCal's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of Kaiser NorCal's self-reported actions.

Table 7.1—Kaiser NorCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP resolves all findings from the October 2018 Medical and State Supported Services Audits.	Kaiser NorCal continues work to close all deficiencies identified during the 2018 Medical and State Supported Services Audits. As of May 2020, only five deficiencies for Kaiser NorCal remain open.
2. Continue to work with DHCS to ensure that the MCP has fully addressed all findings from the October 2017 Medical Audit.	On March 5, 2020, KP Cal, LLC received notice from DHCS' Managed Care Quality and Monitoring Division officially closing out the October 2017 Medical Audit. The notice indicated that all CAP submissions were reviewed for compliance and all deficiencies were closed.
3. Identify the causes for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate declining significantly from reporting year 2018 to reporting year 2019 and develop strategies to address the identified causes.	Kaiser NorCal is investigating systematic ways to actively remind families about routine well care. Historically, the 3-to-6-year-old members come in frequently without outreach. The decline seems unrelated to any change in the pediatrician's practice.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Kaiser NorCal's self-reported actions in Table 7.1 and determined that Kaiser NorCal adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. Kaiser NorCal indicated that it resolved all findings from the 2017 A&I Medical Audit and that it continues to work with DHCS to fully resolve all findings from the 2018 Medical Audit. Additionally, Kaiser NorCal indicated that it is taking steps to implement systematic ways to actively remind families to bring their children in for well-child visits.

2019–20 Recommendations

Based on the overall assessment of Kaiser NorCal's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to fully resolve the findings from the 2018 and 2019 A&I Medical Audits. Kaiser NorCal should thoroughly review all findings and implement the actions recommended by A&I.
- Continue monitoring adopted and adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Contraception* Disparity PIP and *Initial Health Assessment* PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix V:
Performance Evaluation Report
Kaiser SoCal (KP Cal, LLC, in San Diego County)
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, KP Cal, LLC, in San Diego County (commonly known as "Kaiser Permanente South" and referred to in this report as "Kaiser SoCal" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in Kaiser SoCal's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific

activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

Kaiser SoCal is a full-scope MCP delivering services to its members under a Geographic Managed Care (GMC) model. Although the GMC model operates in the counties of San Diego and Sacramento, Kaiser SoCal only operates in San Diego County. In the GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county). In addition to Kaiser SoCal, San Diego County's beneficiaries may select from the following MCPs:

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

Kaiser SoCal became operational in San Diego County to provide MCMC services effective January 1998. As of June 2020, Kaiser SoCal had 49,169 members.[1] This represents 7 percent of the beneficiaries enrolled in San Diego County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Kaiser SoCal. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Kaiser SoCal. A&I conducted the audits from September 30, 2019, through October 11, 2019. A&I assessed Kaiser SoCal's compliance with its DHCS contract and determined to what extent the MCP had implemented its CAP from the 2018 Medical Audit. Note that the CAP from the 2018 audit is still open.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Kaiser SoCal Audit Review Period: September 1, 2018, through August 31, 2019

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

Follow-Up on 2017 Medical Audit

A&I conducted a Medical Audit of Kaiser SoCal in October 2017. HSAG provided a summary of the audit results and status in Kaiser SoCal's 2017–18 and 2018–19 MCP-specific evaluation reports. At the time of both reports' publication, Kaiser SoCal's CAP was in process and under review by DHCS. A letter dated March 5, 2020, stated that Kaiser SoCal provided DHCS with additional information regarding the CAP, and that DHCS had reviewed the information and closed the CAP. The letter indicated that DHCS would monitor the MCP's full implementation of the CAP during the subsequent audit.

Strengths—Compliance Reviews

A&I identified no findings in the State Supported Services category during the 2019 Medical and State Supported Services Audits of Kaiser SoCal. Additionally, in response to the CAP from the October 2017 A&I Medical Audit, Kaiser SoCal submitted documentation to DHCS regarding the actions the MCP took to resolve the findings DHCS identified during the audit. Kaiser SoCal's documentation resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

Kaiser SoCal has the opportunity to work with DHCS to fully resolve the findings from the 2018 and 2019 A&I Medical Audits. During the 2019 Medical Audit, A&I identified repeat findings in the Utilization Management, Access and Availability of Care, Member's Rights, and Quality Management categories. Kaiser SoCal should thoroughly review all findings and implement the actions recommended by A&I.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Kaiser SoCal uses KP Health Connect, an electronic health record system, which allows providers to enter service information directly into the system, resulting in a higher degree of data capture and completeness. As a result, DHCS allows the MCP to report all MCAS measures using the administrative method.

[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- ♦ Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- ♦ Additional technical assistance calls with DHCS Nurse Consultant staff.
- ♦ In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of Kaiser SoCal, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Kaiser SoCal* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for Kaiser SoCal's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Kaiser SoCal—San Diego County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	44.59%
Childhood Immunization Status—Combination 10	57.07%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	98.30%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	90.33%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	92.82%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	91.77%
Developmental Screening in the First Three Years of Life—Total	78.72%
Immunizations for Adolescents—Combination 2	58.65%

Measure	Reporting Year 2020 Rate
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	98.89%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	77.85%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.66%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Kaiser SoCal—San Diego County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	84.02%
Cervical Cancer Screening	83.12%
Chlamydia Screening in Women—Ages 16–20 Years	63.31%
Chlamydia Screening in Women—Ages 21–24 Years	83.42%
Chlamydia Screening in Women—Total	72.21%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	25.41%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	33.87%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	4.19%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.97%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	20.29%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	47.58%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	3.14%
Prenatal and Postpartum Care—Postpartum Care	80.89%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	92.15%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Kaiser SoCal—San Diego County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	74.98%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	52.69%

Measure	Reporting Year 2020 Rate
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	63.21%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	63.79%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	55.78%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	17.34%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	8.67%

Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Kaiser SoCal—San Diego County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	98.40%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	31.95
Asthma Medication Ratio—Total	88.44%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	18.45%

Measure	Reporting Year 2020 Rate
Comprehensive Diabetes Care—HbA1c Testing—Total	95.98%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	18.11%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	12.83%
Controlling High Blood Pressure—Total	84.23%
HIV Viral Load Suppression—Ages 18–64 Years	87.36%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	6.93%
Plan All-Cause Readmissions—Expected Readmissions—Total	8.40%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.83
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.62%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, Kaiser SoCal will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Kaiser SoCal—San Diego County

[green] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

[red] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	54.58	27.79	Not Tested	31.95
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	98.30%	Not Comparable	98.30%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	95.45%	90.18%	5.27	90.33%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	96.49%	92.71%	3.78	92.82%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	96.43%	91.64%	4.79	91.77%
*Plan All-Cause Readmissions—Total***	10.27%	6.10%	4.17	6.93%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that Kaiser SoCal stratified by the SPD and non-SPD populations and for which HSAG could make a comparison between the reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results:

- The reporting year 2020 SPD rates were significantly better than the reporting year 2020 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *12–19 Years* measures.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Kaiser SoCal's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Kaiser SoCal report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the reporting year 2020 rates for each required MLTSSP performance measure. Table 4.1 presents reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 4.1—Reporting Year 2020 MLTSSP Performance Measure Results Kaiser SoCal—San Diego County

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	35.51
*Plan All-Cause Readmissions—Observed Readmissions—Total***	6.83%
Plan All-Cause Readmissions—Expected Readmissions—Total	8.31%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.82

5. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, Kaiser SoCal submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, Kaiser SoCal initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, Kaiser SoCal identified depression screening among Hispanic and Latino members ages 18 and older as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure results reported by the MCP for its *Depression Screening* Disparity PIP.

Table 5.1—Kaiser SoCal *Depression Screening* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of clinical depression screenings completed using an age-appropriate standardized tool among Hispanic or Latino members ages 18 and older assigned to Kaiser Permanente Center A[6]	16.28%	33.00%	No

[6] Center name removed for confidentiality.

Table 5.2 presents a description of the interventions that Kaiser SoCal tested for its *Depression Screening* Disparity PIP. The table also indicates the failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.2—Kaiser SoCal *Depression Screening* Disparity PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Conduct a Patient Health Questionnaire (PHQ)–2 depression screening on all Hispanic/Latino members ages 18 years and older who have not been screened for depression within the past year	♦ Current workflow does not address a PHQ depression screening without an active diagnosis of depression	Adapt
Contact members by phone to complete a PHQ–9 depression screening if physicians document an initial depression diagnosis, and a depression screening was not completed during an office visit	♦ Physicians document a depression diagnosis code in electronic health records (EHRs), but PHQ–9 is not completed ♦ Physicians do not ask nurses to give patients a PHQ–9 to complete	Abandon
Conduct a PHQ–2 depression screening on all members ages 18 years and older who have not been screened for depression within the past year	♦ Current workflow does not address PHQ depression screening without an active diagnosis of depression	Continue Testing
Conduct culturally sensitive care training for providers and staff members	♦ Physicians do not assess for depression ♦ Members decline to complete a PHQ–9 depression screening	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Kaiser SoCal's *Depression Screening* Disparity PIP. Kaiser SoCal documented in the modules that it tested four interventions. In November 2018, the MCP tested having the health center front desk staff member identify, during appointment check-ins, Hispanic/Latino members ages 18 years and older who had not been screened for depression within the past year and request those members to complete a PHQ–2 depression screening using a laminated PHQ–2 questionnaire

and grease pen. If a member scored positive on the PHQ–2 screening, then the front desk staff member requested the member to complete a PHQ–9 depression screening. Based on evaluation effectiveness, Kaiser SoCal determined that the intervention was successful but resource intensive; therefore, the MCP decided to stop the intervention and consider the following adaptations:

- Request all members to complete the PHQ–2 depression screening during check-in.
- Conduct telephonic follow-up with members who had PHQ–2 positive results to complete the PHQ–9 depression screening with these members over the phone.
- Explore having members use iPad tablets to complete PHQ–2 and PHQ–9 depression screenings electronically with automated upload to the EHR system.

Following the initial in-office PHQ–2 intervention testing, Kaiser SoCal tested conducting a telephonic PHQ–9 depression screening for members newly identified with a depression diagnosis. The MCP tested this intervention from November 2018 through January 2019; however, the MCP determined this intervention was not successful due to the low volume of new depression diagnoses during the testing period. Kaiser SoCal decided to abandon this intervention.

In May and June 2019, Kaiser SoCal adapted the in-office PHQ–2 intervention and tested conducting a PHQ–2 screening during check-in among all members ages 18 and older who had not been screened for depression in the past year. While the MCP did not see positive results during the eight weeks of testing the intervention, the MCP decided to continue testing to determine the long-term impact of the intervention.

Lastly, in May 2019, Kaiser SoCal tested the effectiveness of conducting Hispanic/Latino cultural sensitivity training for providers and staff members. Based on the post-training survey, the MCP learned that 16.7 percent of the providers and staff members who received the training reported an increased comfort level with working confidently with Hispanic/Latino members following the training. Kaiser SoCal decided to adapt the training for other staff members.

Despite Kaiser SoCal's efforts, the MCP did not achieve the SMART Aim goal. Upon assessment of the validity and reliability of the PIP results, HSAG assigned Kaiser SoCal's *Depression Screening* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Due to Kaiser SoCal demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. Based on its MCP-specific data, Kaiser SoCal selected adolescent human papillomavirus (HPV) vaccinations as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure results as reported by the MCP for its *Adolescent Vaccinations* PIP.

Table 5.3—Kaiser SoCal *Adolescent Vaccinations* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of HPV two-dose or three-dose vaccination series completions among members 13 years of age	49.9%	55.0%	Yes

Table 5.4 presents a description of the interventions that Kaiser SoCal tested for its *Adolescent Vaccinations* PIP. The table also indicates the failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.4—Kaiser SoCal *Adolescent Vaccinations* PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Improve workflow by identifying 10-year-old members who are due for their HPV vaccinations and document vaccinations due in EHRs	Medical assistants and nurses do not identify that HPV vaccinations are due for members younger than 11 years old	Adopt
Implement a new process to administer immunizations at non-well-care visits	Physicians do not identify when HPV vaccinations are due	Adopt
Schedule second HPV vaccine appointments during the first HPV vaccine appointment visits	Face-to-face visits for second HPV vaccinations are not scheduled prior to appointment departure	Abandon

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Kaiser SoCal's *Adolescent Vaccinations* PIP. Kaiser SoCal documented in the modules that it originally planned to test four interventions; however, due to staffing changes and other competing priorities, the MCP determined to postpone an intervention designed to train clinic nursing staff members on communication strategies to use with members and parents regarding HPV vaccinations.

Starting in June 2018, the MCP began testing an intervention to improve the nursing staff members' workflow by identifying 10-year-old members who were due for HPV vaccinations and noting the vaccinations due in the EHR system. The MCP determined that the intervention contributed to more 10-year-old members being vaccinated, which will ultimately impact the rate of HPV vaccination series completed by the member's 13th birthday. Kaiser SoCal decided to adopt this intervention.

In October 2018, the MCP initiated testing a new process to administer HPV vaccinations to adolescents during non-well-care visits. Kaiser SoCal determined that the intervention was successful and recognized that every visit can be an opportunity to update and complete members' vaccinations. The MCP adopted this intervention.

From October 2018 through January 2019, Kaiser SoCal tested the impact of scheduling the member's second HPV vaccination appointment at the time of the first HPV vaccination appointment visit. The MCP noted that this intervention did not result in many second HPV vaccination appointments being scheduled; therefore, the MCP abandoned the intervention.

Kaiser SoCal achieved the SMART Aim goal, with the highest monthly SMART Aim rate occurring in February 2019. Upon assessment of the validity and reliability of the PIP results, HSAG assigned Kaiser SoCal's *Adolescent Vaccinations* PIP a final confidence level of *High Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, Kaiser SoCal identified well-child visits for members ages 3 to 6 years as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP. Upon initial review of the modules, HSAG determined that Kaiser SoCal met some required validation criteria for Module 1; however, HSAG identified opportunities for improvement related to including all required components of the SMART Aim data collection methodology. After receiving technical assistance from HSAG, Kaiser SoCal incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. Kaiser SoCal met all Module 2 validation criteria in its initial submission. The MCP was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, Kaiser SoCal selected adolescent well-care visits as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Adolescent Well-Care Visits* PIP. Upon initial review of the modules, HSAG determined that Kaiser SoCal met some required validation criteria; however, HSAG identified opportunities for improvement related to including:

- All required components of the:
  - SMART Aim statement.
  - SMART Aim data collection methodology.
  - SMART Aim run chart.
- A process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.

After receiving technical assistance from HSAG, Kaiser SoCal incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the MCP met all validation criteria for Module 1. Kaiser SoCal received the initial Module 2 validation findings when DHCS determined to end the 2019–21 PIPs; therefore, the MCP did not have an opportunity to incorporate HSAG's feedback into Module 2.

Strengths—Performance Improvement Projects

Kaiser SoCal achieved the SMART Aim goal for the 2017–19 *Adolescent Vaccinations* PIP, and all of the quality improvement activities could be linked to the demonstrated improvement. Based on its assessment, HSAG assigned the 2017–19 *Adolescent Vaccinations* PIP a final confidence level of *High Confidence*.

Upon completion of the 2017–19 PIPs, Kaiser SoCal identified interventions that it can adopt and adapt to increase the number of members who complete depression screenings as well as the number of adolescents who receive HPV vaccinations.

Opportunities for Improvement—Performance Improvement Projects

Kaiser SoCal has the opportunity to continue monitoring adopted and adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Depression Screening* Disparity PIP and *Adolescent Vaccinations* PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

Kaiser SoCal submitted the MCP's PNA report to DHCS on June 30, 2020, and DHCS notified the MCP via email on July 24, 2020, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from Kaiser SoCal's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of Kaiser SoCal's self-reported actions.

Table 8.1—Kaiser SoCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP resolves all findings from the October 2018 Medical and State Supported Services Audits.	Kaiser SoCal continues work to close all deficiencies identified during the 2018 Medical and State Supported Services Audits. As of May 2020, five deficiencies for Kaiser SoCal remain open.
2. Continue to work with DHCS to ensure that the MCP has fully addressed all findings from the October 2017 Medical Audit.	On March 5, 2020, KP Cal, LLC received notice from DHCS' Managed Care Quality and Monitoring Division officially closing out the October 2017 Medical Audit. The notice indicated that all CAP submissions were reviewed for compliance and all deficiencies were closed.
3. Identify the causes for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate declining significantly from reporting year 2018 to reporting year 2019 and develop strategies to address the identified causes.	The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure declined from 73.95 percent for reporting year 2018 to 71.06 percent for reporting year 2019. This represents a statistically significant rate difference of -2.89 (p <.05).

2018–19 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	Potential causes for the reporting year 2019 decline include: ♦ A new call center phone system was implemented in 2018 that integrates with KP HealthConnect EHR and other information systems to efficiently support centralized appointment scheduling. An unanticipated consequence of the system's artificial intelligence logic was longer call duration time which resulted in extended call wait times and fewer calls handled. The new system was suspended while revisions were made to improve efficiency. The system was successfully re-deployed in 2019. ♦ Member outreach was conducted monthly by office staff members to schedule well-care visit appointments. A limitation was inconsistent staff member availability and inefficiency of conducting manual phone outreach. Automated outreach was initiated in 2019. The Kaiser San Diego Ambulatory Pediatric Department utilizes a multi-pronged approach to address performance of this measure: ♦ Access: Appointment access is proactively managed through analysis of the predicted volume of patients for each clinic and available slots. The Pediatric Department uses this information to proactively book appointments and adjust staffing. ♦ Outreach: Automated outreach is conducted monthly by voice, text, or phone message, asking parents to schedule a well-care visit appointment. Pediatric members are targeted one month before their 3rd, 4th, 5th, and 6th birthday if they have not had a well-care visit in the past 18 months and do not have a scheduled well-care visit.

2018–19 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ Meaningful Work Initiative: Clinical office staff are assigned to do “Meaningful Work” by using the Panel Management Tool in the HealthConnect EHR to identify and outreach to members who are due for well-care visits. ♦ Care Gap Identification: Providers and office staff members utilize Proactive Office Encounter (POE), an automated rule-driven EHR workflow to identify open care gaps in the patient charts. The POE drives the providers and staff members to schedule the next well-care visit. Staff members check POE at all patient touchpoints. ♦ Follow-up on No-Show Missed Appointments: Automated calls are generated for all appointments, asking parents to reschedule the appointment. ♦ The Kaiser San Diego Ambulatory Pediatric Quality Committee reviews performance measure scorecards and improvement initiatives monthly and takes proactive action to address opportunities. Committee members include pediatric and primary care physician leadership; executive and medical office clinical, administrative, and quality improvement leadership; and data/analytic membership. ♦ A Medi-Cal Health Equity PIP was initiated in 2019: *Well-Child Visits Ages 3 to 6, White vs. Hispanic/Latino Disparity*. The PIP topic is focused on addressing an identified disparity and overall performance trending below the 50th percentile minimum performance level.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Kaiser SoCal's self-reported actions in Table 8.1 and determined that Kaiser SoCal adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. Kaiser SoCal indicated that the MCP resolved all findings from the 2017 A&I Medical Audit and that the MCP continues to work with DHCS to fully resolve all findings from the 2018 Medical Audit. Additionally, Kaiser SoCal described in detail results from the MCP's assessment of declining performance for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure and the MCP's multi-pronged approach to prevent further decline in performance. The MCP's approach includes member outreach, care gap identification, follow-up with members who do not attend their appointments, and proactive appointment scheduling.

2019–20 Recommendations

Based on the overall assessment of Kaiser SoCal's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to fully resolve the findings from the 2018 and 2019 A&I Medical Audits. Kaiser SoCal should thoroughly review all findings and implement the actions recommended by A&I.
- Continue monitoring adopted and adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Depression Screening* Disparity PIP and *Adolescent Vaccinations* PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.

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

Medi-Cal Managed Care External Quality Review Technical Report

Appendix W: Performance Evaluation Report Kern Health Systems, DBA Kern Family Health Care

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Kern Health Systems, DBA Kern Family Health Care ("KHS" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in KHS's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

KHS is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in KHS, the Local Initiative MCP, or in Health Net Community Solutions, Inc., the alternative commercial plan.

KHS became operational in Kern County to provide MCMC services effective July 1996. As of June 2020, KHS had 267,193 members in Kern County.[1] This represents 81 percent of the beneficiaries enrolled in Kern County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for KHS. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of KHS. A&I conducted the audits from August 6, 2019, through August 9, 2019.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of KHS
Audit Review Period: August 1, 2018, through July 31, 2019

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

Strengths—Compliance Reviews

In the Medical Audit final report issued on November 14, 2019, A&I noted that in response to the 2018 audit findings in the Administrative and Organizational Capacity category, KHS developed a compliance committee to establish an anti-fraud and abuse program, and A&I identified no findings in this category during the 2020 audits. Additionally, during the audits A&I also identified no findings in the Access and Availability of Care, Administrative and Organizational Capacity, and State Supported Services categories. Finally, in the CAP closeout letter dated May 15, 2020, DHCS indicated that KHS' CAP response regarding the findings in the Utilization Management, Case Management and Coordination of Care, Member's Rights, and Quality Management categories resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

KHS has no outstanding findings from the August 2019 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

KHS chose to report all hybrid measures according to the reporting year 2020 measure specifications using measurement year 2019 data.

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systemic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of KHS, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Kern Health Systems* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that KHS followed the appropriate specifications to produce valid rates; however, during the audit process, the auditor identified an area of concern. The auditor noted that newborn claims were paid by KHS under the mothers' identification numbers until the newborns received permanent State identification numbers; however, KHS did not have a process within its claims system to link these claims back to the newborns. KHS implemented a process to link the newborn identification numbers for the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measure population; however, since the linking process was limited to the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measure population, the auditor requested KHS to investigate any impact on measures with continuous enrollment requirements since there was a potential for underreporting denominators. KHS determined that in total, less than 5 percent of newborns

were not included in the eligible populations of the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* and *Children and Adolescents' Access to Primary Care Practitioners* measures; therefore, the impact was minimal. Of note, KHS' review of newborn enrollment found that most newborns were enrolled with Medi-Cal identification numbers more than 30 days after birth. This greater-than-30-day gap can impact qualifications for eligible populations if the identification numbers are not linked.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for KHS's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
KHS—Kern County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	36.01%
Childhood Immunization Status—Combination 10	29.93%

Measure	Reporting Year 2020 Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	90.39%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	81.59%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	80.95%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	78.07%
Developmental Screening in the First Three Years of Life—Total	5.86%
Immunizations for Adolescents—Combination 2	41.36%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	66.42%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	32.60%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.21%

Assessment of Improvement Plans—Children's Health Domain

In April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that KHS conducted as part of its IP prior to April 2020.

The rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure was below the minimum performance level in reporting year 2019, and DHCS approved KHS to conduct a *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP in place of conducting PDSA cycles to improve the MCP's performance on this measure. HSAG includes a summary of KHS' progress on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP in Section 4 of this report ("Performance Improvement Projects").

DHCS did not hold MCPs accountable to meet the minimum performance level for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure in reporting year 2020; therefore, HSAG makes no assessment of KHS' performance related to this measure.

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
KHS—Kern County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	57.29%
Cervical Cancer Screening	56.20%
Chlamydia Screening in Women—Ages 16–20 Years	45.22%
Chlamydia Screening in Women—Ages 21–24 Years	64.87%
Chlamydia Screening in Women—Total	55.29%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	14.76%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	26.35%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.94%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.51%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.42%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	41.24%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	39.67%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	14.32%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.33%
Prenatal and Postpartum Care—Postpartum Care	81.02%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.18%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
KHS—Kern County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	50.24%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	32.64%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	32.45%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	29.73%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.09%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
KHS—Kern County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	78.10%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	45.67
Asthma Medication Ratio—Total	48.78%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	57.91%
Comprehensive Diabetes Care—HbA1c Testing—Total	85.16%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	6.53%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	38.93%
HIV Viral Load Suppression—Ages 18–64 Years	S
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.04%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.75%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.13

Measure	Reporting Year 2020 Rate
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	29.25%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S

Assessment of Improvement Plans—Acute and Chronic Disease Management Domain

As previously stated, in April 2020, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that KHS conducted as part of its IP prior to April 2020.

The rate for the *Asthma Medication Ratio—Total* measure was below the minimum performance level in reporting year 2019, and DHCS approved KHS to conduct an *Asthma Medication Ratio—Total* PIP in place of conducting PDSA cycles to improve the MCP's performance on this measure. HSAG includes a summary of KHS' progress on the *Asthma Medication Ratio* PIP in Section 4 of this report ("Performance Improvement Projects").

DHCS did not hold MCPs accountable to meet the minimum performance level for the *Asthma Medication Ratio—Total* measure in reporting year 2020; therefore, HSAG makes no assessment of KHS' performance related to this measure.

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, KHS will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations KHS—Kern County

[green] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

[red] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	56.78	44.92	Not Tested	45.67
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	89.80%	90.40%	-0.60	90.39%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	90.66%	81.36%	9.30	81.59%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	86.10%	80.76%	5.34	80.95%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	79.55%	78.01%	1.54	78.07%
*Plan All-Cause Readmissions— Total***	15.65%	9.04%	6.61	11.04%

Seniors and Persons with Disabilities—Performance Measure Findings

HSAG observed the following notable results in reporting year 2020 for measures that KHS stratified by the SPD and non-SPD populations:

- The reporting year 2020 SPD rates were significantly better than the reporting year 2020 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years* and *Ages 7–11 Years* measures.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that KHS followed the appropriate specifications to produce valid rates.

Opportunities for Improvement—Performance Measures

KHS has the opportunity to evaluate the possibility of implementing standardized procedures within the MCP's enrollment/claims system to link newborns to their mothers' identification numbers. If a system-based solution is not feasible for the next reporting period, KHS should expand the use of its member identification number crosswalk and incorporate the crosswalk at the initial stages of HEDIS data integration to eliminate the potential of biased eligible populations and rates.

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, KHS submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, KHS initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCPs experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

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

Table 4.1 provides the SMART Aim measure results reported by the MCP for its *Childhood Immunization Status—Combination 3* Disparity PIP.

Table 4.1—KHS *Childhood Immunization Status—Combination 3* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of *Childhood Immunization Status—Combination 3* measure among African-American children receiving primary care services at Clinic A[6]	19%	40%	No

Table 4.2 presents a description of the interventions that KHS tested for its *Childhood Immunization Status—Combination 3* Disparity PIP. The table also indicates the key drivers

[6] Clinic name removed for confidentiality.

and failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—KHS *Childhood Immunization Status—Combination 3* Disparity PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Add use of growth charts to the vaccine education at postpartum visits to help obtain parents' buy-in to getting their children vaccinated	♦ Education to make an informed decision and parents' buy-in ♦ Parents/guardians are not provided with information about the importance of immunizations ♦ Hearsay of potential side effects	Abandon
Provide Clinic A with a monthly list of members who are noncompliant with the immunization schedule for the provider to contact the parents/guardians and schedule vaccination appointments	♦ Lack of transportation ♦ Access/wait time ♦ Parents/guardians are not provided information on walk-in/Saturday clinics ♦ Parents/guardians are not provided information about transportation assistance and the immunization schedule	Abandon

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for KHS's *Childhood Immunization Status—Combination 3* Disparity PIP. KHS documented in the modules that it tested two interventions. From February 2018 through April 2018, the MCP tested the impact of using informative growth charts to provide education to parents at their postpartum visits about the importance of immunizations. After three months of testing the intervention, KHS noticed that only a small number of the members in the PIP target population attended their postpartum visits; therefore, the MCP decided to abandon the intervention. From April 2018 through June 2019, KHS tested the effectiveness of providing the clinic partner monthly lists of members who were due for immunizations so that the clinic staff members could reach out to the parents/guardians. The MCP documented challenges in getting the clinic partner to fully engage in the intervention testing as well as to provide intervention effectiveness measure data; therefore, KHS determined to abandon this intervention as well. The MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned KHS's *Childhood Immunization Status—Combination 3* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Due to KHS demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an identified area in need of improvement. Based on its MCP-specific data, KHS selected use of imaging studies for lower back pain as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure results as reported by the MCP for its *Use of Imaging Studies for Lower Back Pain* PIP.

Table 4.3—KHS *Use of Imaging Studies for Lower Back Pain* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of members diagnosed with uncomplicated lower back pain, ages 18 to 50, and assigned to Provider B[7] who did not have an imaging study	85.29%	95.29%	No

Table 4.4 presents a description of the interventions that KHS tested for its *Use of Imaging Studies for Lower Back Pain* PIP. The table also indicates the key drivers and failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

[7] Provider name removed for confidentiality.

Table 4.4—KHS *Use of Imaging Studies for Lower Back Pain* PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Schedule a two-week follow-up appointment prior to the member leaving the clinic on the initial visit	♦ Members' inability to know what to do and where to go ♦ Intensity of pain and poor control	Abandon
Review medical records to identify promising practices and develop standardized protocol for lower back pain treatment	♦ Some providers practicing "defensive medicine" ♦ Ineffective lower back pain management protocol ♦ No standardized protocol for treatment plan ♦ Conservative treatment varies from provider to provider	Abandon

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for KHS's *Use of Imaging Studies for Lower Back Pain* PIP. KHS submitted plans to test three interventions in total; however, the MCP documented that due to lack of resources and leadership changes at the provider partner site, the MCP was not able to test the implementation of provider compliance awareness and standardized education to promote the use of standardized treatment protocol. KHS was able to test the other two planned interventions. From January 2019 through March 2019, KHS tested the impact of scheduling a two-week follow-up visit prior to the members leaving the clinic after their initial visits. Based on evaluation results, the MCP concluded that the two-week follow-up visit scheduling intervention did not impact the SMART Aim and determined to abandon the intervention. From April 2019 through June 2019, KHS reviewed medical records to identify promising practices for lower back pain treatment. The MCP was able to identify the top five promising practices and shared the information with the provider partner to develop a standardized treatment protocol for lower back pain. KHS determined to abandon the intervention since it was able to identify the promising practices, and no further follow-up actions were needed. Despite KHS's efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned KHS's *Use of Imaging Studies for Lower Back Pain* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, KHS identified children's health among members living in Central Bakersfield as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 through 3 for the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP. HSAG determined that KHS met all validation criteria for all three modules in the MCP's initial submissions.

Table 4.5 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP.

Table 4.5—KHS *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of well-child visits among 6-year-old members assigned to Provider C[8]	51%	71%

Table 4.6 presents a description of the intervention that KHS selected to test for its *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP. The table also indicates the failure modes that the intervention aims to address.

[8] Provider name removed for confidentiality.

Table 4.6—KHS *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* Health Equity PIP Intervention Testing

Intervention	Failure Modes Addressed
Schedule Saturday clinics twice a month for four months with a focus on completing well-child visits for 6-year-old members assigned to Provider C	♦ Schools making it difficult to take children out of class for well-child visit appointments ♦ Parents/guardians unable to take off work

While KHS advanced to the intervention testing phase, the MCP provided an update in April 2020 in response to HSAG conducting a check-in, indicating the MCP had to delay intervention testing due to COVID-19. HSAG requested no additional updates from KHS prior to DHCS determining to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, KHS selected asthma medication ratio among children and adolescents as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 through 3 for the MCP's *Asthma Medication Ratio* PIP. Upon initial review of the modules, HSAG determined that KHS met all required validation criteria for Module 2; however, HSAG identified opportunities for improvement related to the following modules 1 and 3 validation criteria:

- Including all required components of the SMART Aim, SMART Aim data collection methodology, and SMART Aim run chart.
- Ensuring that the intervention effectiveness measure was appropriate for the intervention.
- Ensuring that the data collection process was appropriate for the intervention effectiveness measure.

After receiving technical assistance from HSAG, KHS incorporated HSAG's feedback into modules 1 and 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 3.

Table 4.7 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the *Asthma Medication Ratio* PIP.

Table 4.7—KHS *Asthma Medication Ratio* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of asthma medication ratio of 0.5 or greater among members 5 to 18 years of age who were diagnosed with persistent asthma and assigned to Provider D[9]	74%	86%

Table 4.8 presents a description of the intervention that KHS selected to test for its *Asthma Medication Ratio* PIP. The table also indicates the failure modes that the intervention aims to address.

Table 4.8—KHS *Asthma Medication Ratio* PIP Intervention Testing

Intervention	Failure Modes Addressed
Provide monthly list of members who are not compliant with the *Asthma Medication Ratio* measure, until the Provider Portal is updated	♦ No gap-in-care list available on Provider Portal for provider to identify members who are not compliant for the measure ♦ Provider office does not have system in place in the electronic health record system to identify asthma medication ratio ♦ Provider is unable to optimize persistent asthma management

While KHS advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

As a result of the 2017–19 *Use of Imaging Studies for Lower Back Pain* PIP, KHS identified five promising practices for lower back pain treatment which may be used by providers to develop a standardized treatment protocol for low back pain.

Opportunities for Improvement—Performance Improvement Projects

KHS has the opportunity to apply the lessons learned from the 2017–19 PIPs to facilitate improvement for future PIPs.

[9] Provider name removed for confidentiality.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

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

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* (“Population Needs Assessment”) provides additional details regarding DHCS’ PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

KHS submitted the MCP’s PNA report to DHCS on July 10, 2020, and DHCS notified the MCP via email on July 13, 2020, that DHCS approved the report as submitted. While KHS submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 7.1 provides EQR recommendations from KHS's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of KHS's self-reported actions.

Table 7.1—KHS's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Assess whether the MCP should make changes to its current improvement strategies related to the *Asthma Medication Ratio* measure to ensure that beneficiaries ages 5 to 64 who are identified as having persistent asthma have a ratio of controller medications to total asthma medications of 0.50 or greater. (The rates for this measure were below the minimum performance levels in reporting year 2018 and reporting year 2019.)	KHS identified a more accurate process for prescription counts for asthma medications. It was approved by both HSAG and NCQA. The revised logic includes eliminating denied pharmacy claims for asthma medications since they would not have been dispensed and the denied claims were generating an inaccurately inflated numerator and denominator. This change increased the compliance rate for the *Asthma Medication Ratio* measure to a higher level (approximately 30 percent higher) and to a rate that was accurate. KHS also initiated the *Asthma Medication Ratio* PIP, which focused on improving the *Asthma Medication Ratio* measure compliance for children 5 to 11 and 12 to 18 years of age. On July 25, 2019, DHCS approved KHS to use this PIP in lieu of a separate IP for the *Asthma Medication Ratio* measure. This PIP has been ongoing up until July 2020, at which time DHCS determined to temporarily suspend all

2018–19 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	PIP requirements due to the COVID-19 pandemic. KHS participated in the program, Asthma Impact Model, with the Central California Asthma Coalition (CCAC). KHS partners each year with CCAC and a local hospital to sponsor an annual Asthma Forum for provider education on the management of asthma. We also ran a pilot with CCAC to provide in-home assessment and education for 40 KHS members with asthma. The assessment and education included appropriate use of their asthma controllers and rescue medications. Transportation was implemented and is promoted as a benefit to all our members. The addition of transportation assistance supports members in being able to make and keep appointments with their providers, pick up medications from the pharmacy, and attend asthma education classes offered by KHS.
2. To improve the MCP's performance to above the minimum performance level for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, determine the factors preventing beneficiaries ages 3 to 6 from being seen for one or more well-child visit(s) with a PCP during the measurement year, and identify strategies to address the factors.	According to the 2017 Kern County Report Card, 32 percent of all children live in families with incomes below the federal poverty level—$24,600 a year for a family of four. Poverty threatens every aspect of a child's well-being including his or her physical, social, and emotional health; safety; and ability to learn. KHS identified the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure as an area in need of improvement, with a MCAS/HEDIS score reported in June 2019 of 63.99 percent. A proposal for a 2019–21 PIP was submitted to and accepted by HSAG on July 26, 2019. KHS chose a high-volume, low-performing pediatric provider whose office location of

2018–19 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	Downtown Bakersfield serves among the lowest median household incomes within the Bakersfield city limits. Module 1 of the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP was accepted by HSAG on November 15, 2019. Barriers identified to completing well-child visits included: ♦ No weekend hours ♦ A lack of transportation ♦ The length of time it takes to complete a well-child visit Our first intervention involved holding clinic hours every other Saturday and was initiated on March 14, 2020. KHS supported the activity by providing lunch to the staff members at a pediatric office on that kick-off day. On March 24, 2020, the COVID-19 pandemic had evolved to a State mandate to “shelter-in-place” which created a decrease in office staff members and providers. Those clinical staff were focused on treating only acutely ill children. As a result, the intervention of Saturday clinics was put on hold. This PIP has been ongoing up until July 2020, at which time DHCS ended all current PIPs due to the COVID-19 pandemic. KHS will likely resurrect this PIP when DHCS initiates a new cycle of PIPs. In addition to the PIP, KHS has a pay-for-performance (P4P) Program in place as an incentive for providers who want to increase compliance with several preventive health services. KHS has included well-child visits for children ages 3 to 6 years as one of the P4P

2018–19 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	measures since 2013 and financially rewards providers for completing those visits with our members. Unfortunately, well-child visits have become a lower priority due to the COVID-19 pandemic. KHS is actively supporting providers to schedule members for appointments for important preventive care through provider newsletters and posting recommendation postcards from DHCS and the California Department of Public Health on our provider website. KHS is implementing a Member Engagement and Incentive Program that focuses on member outreach to notify them of important preventive health information they need and incentivize those who follow through with receiving the services. The program identifies members with gaps in care for select measures, and then outreach and incentivization efforts focus on those measures. The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure is included in the measures for that program set to begin in August 2020.

Assessment of MCP's Self-Reported Actions

HSAG reviewed KHS' self-reported actions in Table 7.1 and determined that KHS adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. KHS described in detail actions taken during the review period to improve performance on the *Asthma Medication Ratio* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures. For both measures, KHS described more than one strategy the MCP implemented to ensure accurate performance measure rates, improve performance, and support members in receiving needed services. KHS also documented the effects COVID-19 had on improvement efforts and steps the MCP plans to take moving forward to improve performance.

2019–20 Recommendations

Based on the overall assessment of KHS's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Evaluate the possibility of implementing standardized procedures within the MCP's enrollment/claims system to link newborns to their mothers' identification numbers. If a system-based solution is not feasible for the next reporting period, KHS should expand the use of its member identification number crosswalk and incorporate the crosswalk at the initial stages of HEDIS data integration to eliminate the potential of biased eligible populations and rates.
- Apply the lessons learned from the 2017–19 PIPs to facilitate improvement for future PIPs.

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

Medi-Cal Managed Care External Quality Review Technical Report

Appendix X: Performance Evaluation Report L.A. Care Health Plan

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, L.A. Care Health Plan ("L.A. Care" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in L.A. Care's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

L.A. Care is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in L.A. Care, the Local Initiative MCP, or in Health Net Community Solutions, Inc., the alternative commercial plan.

L.A. Care became operational in Los Angeles County to provide MCMC services effective March 1997. As of June 2020, L.A. Care had 2,043,357 members in Los Angeles County.[1] This represents 69 percent of the beneficiaries enrolled in Los Angeles County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for L.A. Care.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of L.A. Care. A&I conducted the audits from July 15, 2019, through July 26, 2019. During the audits, A&I assessed L.A. Care's compliance with the corrective action plan (CAP) from the 2018 audits, which DHCS closed on May 16, 2019. DHCS issued the final closeout letter on September 2, 2020, which is outside the review period for this report; however, HSAG includes the information because it reflects full resolution of the findings from the 2019 A&I Medical Audit.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of L.A. Care Audit Review Period: July 1, 2018, through June 30, 2019

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

Strengths—Compliance Reviews

A&I identified no findings in the Member's Rights, Quality Management, Administrative and Organizational Capacity, and State Supported Services categories during the July 2019 Medical and State Supported Services Audits of L.A. Care. Additionally, in response to the CAP from the 2019 A&I Medical Audit of L.A. Care, the MCP provided documentation to DHCS that resulted in DHCS closing the CAP. L.A. Care's documentation reflected changes to policies and procedures to ensure the MCP is compliant with DHCS' standards within the Utilization Management, Case Management and Coordination of Care, and Access and Availability of Care categories.

Opportunities for Improvement—Compliance Reviews

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

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

L.A. Care chose to report all hybrid measures according to the reporting year 2020 measure specifications using measurement year 2019 data.

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of L.A. Care, and the *HEDIS 2020 Compliance Audit Final Report of Findings for L.A. Care Health Plan* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for L.A. Care's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
L.A. Care—Los Angeles County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	59.12%
Childhood Immunization Status—Combination 10	37.47%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	92.35%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	83.66%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	87.77%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	85.43%

Measure	Reporting Year 2020 Rate
Developmental Screening in the First Three Years of Life—Total	15.14%
Immunizations for Adolescents—Combination 2	41.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	85.83%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	55.72%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.21%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
L.A. Care—Los Angeles County

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	62.65%
Cervical Cancer Screening	66.91%
Chlamydia Screening in Women—Ages 16–20 Years	63.54%
Chlamydia Screening in Women—Ages 21–24 Years	72.29%
Chlamydia Screening in Women—Total	68.01%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	12.36%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	22.49%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	1.74%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.94%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	1.48%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	3.30%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	22.82%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	22.33%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.60%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.47%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	7.05%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	5.76%
Prenatal and Postpartum Care—Postpartum Care	73.48%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.75%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
L.A. Care—Los Angeles County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	58.50%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.04%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	57.18%

Measure	Reporting Year 2020 Rate
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	68.47%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	14.53%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	6.09%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	7.30%

Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
L.A. Care—Los Angeles County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	94.71%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	46.45
Asthma Medication Ratio—Total	59.56%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	36.74%
Comprehensive Diabetes Care—HbA1c Testing—Total	91.73%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	14.80%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	12.53%
Controlling High Blood Pressure—Total	69.59%
HIV Viral Load Suppression—Ages 18–64 Years	3.34%

Measure	Reporting Year 2020 Rate
HIV Viral Load Suppression—Ages 65+ Years	1.96%
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.74%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.66%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.80
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.11%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	1.87%

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, L.A. Care will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations L.A. Care—Los Angeles County

[Light green box] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

[Red box] = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	81.20	44.04	Not Tested	46.45
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	91.21%	92.36%	-1.15	92.35%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	88.65%	83.54%	5.11	83.66%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	91.98%	87.60%	4.38	87.77%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	89.29%	85.27%	4.02	85.43%
*Plan All-Cause Readmissions—Total***	9.36%	7.15%	2.21	7.74%

Seniors and Persons with Disabilities—Performance Measure Findings

HSAG observed the following notable results in reporting year 2020 for measures that L.A. Care stratified by the SPD and non-SPD populations:

- The reporting year 2020 SPD rates were significantly better than the reporting year 2020 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years*, *Ages 7–11 Years*, and *Ages 12–19 Years* measures.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to L.A. Care's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that L.A. Care report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the reporting year 2020 rates for each required MLTSSP performance measure. Table 4.1 presents reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 4.1—Reporting Year 2020 MLTSSP Performance Measure Results
L.A. Care—Los Angeles County

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	64.76
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.40%
Plan All-Cause Readmissions—Expected Readmissions—Total	10.45%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.90

5. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, L.A. Care submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, L.A. Care initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

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

Table 5.1 provides the SMART Aim measure results reported by the MCP for its *Diabetes Medication Adherence* Disparity PIP.

Table 5.1—L.A. Care *Diabetes Medication Adherence* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of proportion of days covered for diabetes medication of less than 0.8 among African-American members, ages 35 to 45, who are not assigned to L.A. County Department of Health Services clinics	54%	38%	No

Table 5.2 presents a description of the interventions that L.A. Care tested for its *Diabetes Medication Adherence* Disparity PIP. The table also indicates the failure modes that each intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.2—L.A. Care *Diabetes Medication Adherence* Disparity PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Contacting members by phone who have missed at least one refill to: ♦ Address any barriers ♦ Inform them about the mail order program in which members can receive a 90-day supply of medication ♦ Attempt to secure refills	Members are not aware of what to do when they reach the maximum number of refills	Abandon
Conduct health messaging campaign on diabetes management and medication adherence	Members do not believe they need medications	Continue Testing

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for L.A. Care's *Diabetes Medication Adherence* Disparity PIP. L.A. Care documented in the modules that it tested two interventions. From July 2018 through March 2019, the MCP tested the impact of contacting members to address barriers to medication adherence, inform the members about the 90-day supply mail order program, and attempt to secure refills for the members. The MCP documented that it was difficult to reach members and only a few members were interested in participating in the phone conversation. Thus, L.A. Care abandoned the telephonic outreach intervention.

In May 2019, L.A. Care began testing the effectiveness of conducting a health messaging campaign about diabetes management and medication adherence. The MCP used billboards, bus shelter locations, and a website to launch various health messages. The MCP determined that additional time is required to evaluate the effectiveness of the health messaging campaign. L.A. Care indicated that it will attempt to obtain additional funding to continue the intervention for a longer period of time in additional geographic areas with low diabetes medication adherence rates.

Despite L.A. Care's efforts, the MCP did not achieve the SMART Aim goal. Upon assessment of the validity and reliability of the PIP results, HSAG assigned L.A. Care's *Diabetes Medication Adherence* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on L.A. Care's reporting year 2017 performance measure results, the MCP selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure results as reported by the MCP for its *Childhood Immunization Status—Combination 3* PIP.

Table 5.3—L.A. Care *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of *Childhood Immunization Status—Combination 3* measure in San Gabriel Valley	40.9%	51.0%	No

Table 5.4 presents a description of the intervention that L.A. Care tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.4—L.A. Care *Childhood Immunization Status—Combination 3* PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Offering assistance to provider offices that do not actively use the California Immunization Registry—focusing on connecting electronic health record systems (EHRs) to the California Immunization Registry and coaching staff members on data entry and use of the California Immunization Registry	♦ Providers do not enter data into the California Immunization Registry ♦ Providers do not participate in the California Immunization Registry	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for L.A. Care's *Childhood Immunization Status—Combination 3* PIP. L.A. Care documented in the modules that it tested the effectiveness of visiting provider offices to assess their use of the California Immunization Registry and providing assistance to those sites that do not actively use the registry. The MCP focused on connecting the provider sites' EHRs to the California Immunization Registry and coaching staff members on entering the data into the registry. The MCP tested the intervention from July 2018 through June 2019, and the MCP determined that the intervention was effective and decided to adapt the intervention.

Despite L.A. Care's efforts, the MCP did not achieve the SMART Aim goal. Upon assessment of the validity and reliability of the PIP results, HSAG assigned L.A. Care's *Childhood Immunization Status—Combination 3* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, L.A. Care identified asthma medication ratio as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Asthma Medication Ratio* Health Equity PIP. Upon initial review of the modules, HSAG determined that L.A. Care met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.
- Including all required components of the SMART Aim run chart.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Labeling clearly the identified gaps or opportunities for improvement in the process map steps.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.

After receiving technical assistance from HSAG, L.A. Care incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. L.A. Care was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, L.A. Care selected childhood immunizations as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Childhood Immunization Status—Combination 10* PIP. Upon initial review of the modules, HSAG determined that L.A. Care met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.
- Including all required components of the SMART Aim run chart.
- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.
- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.

After receiving technical assistance from HSAG, L.A. Care incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. L.A. Care was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, L.A. Care identified interventions that it can continue to test and adapt to improve members' adherence to diabetes medications and childhood immunizations.

Opportunities for Improvement—Performance Improvement Projects

L.A. Care has the opportunity to monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 3* PIP. Additionally, L.A. Care has the opportunity to continue testing the health messaging campaign intervention from the 2017–19 *Diabetes Medication Adherence* Disparity PIP to determine its effectiveness for improving diabetes medication adherence in areas with low adherence rates.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

L.A. Care submitted the MCP's final PNA report to DHCS on July 20, 2020, and DHCS notified the MCP via email on July 24, 2020, that DHCS approved the report as submitted. While L.A. Care submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from L.A. Care's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of L.A. Care's self-reported actions.

Table 8.1—L.A. Care's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Identify the causes for the *Asthma Medication Ratio* measure rate declining significantly from reporting year 2018 to reporting year 2019 and develop strategies, as applicable, to address the significant decline.	♦ Barriers ■ There was incomplete visibility to the eligible population during the measurement year. During measurement year 2019, there were low population sizes and high rates; however, by the end of the year the population size increased, and rates decreased. We are currently investigating the cause for low numbers of members throughout the year and high numbers visible in the month of December. ■ Members are refilling asthma relievers without seeing their provider, or if they see their provider, the primary diagnosis is not asthma. ■ Lack of clear measure coding guides and instructions for providers to properly code for the *Asthma Medication Ratio* measure.

2018–19 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ Interventions ■ Measure coding guides were developed, and L.A. Care providers were directed during outreach and throughout the year to the guide to ensure proper measure coding. ■ Collaboration with the pharmacy department to develop asthma labels (controllers and relievers) for member use to encourage controller usage and to differentiate between controllers and relievers. ■ Partnering with the Los Angeles County Department of Health Services to launch asthma PIP interventions including conducting educational webinars, developing asthma action plans, and promoting updated pharmacy tools for providers. ■ The *Asthma Medication Ratio* measure continues to be displayed in our prospective gap-in-care reports and members' *Asthma Medication Ratio* values have been added as part of the incentive program.

Assessment of MCP's Self-Reported Actions

HSAG reviewed L.A. Care's self-reported actions in Table 8.1 and determined that L.A. Care adequately addressed HSAG's recommendation from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. L.A. Care described in detail barriers it identified that contributed to the significant decline in the *Asthma Medication Ratio* measure rate from reporting year 2018 to reporting year 2019. Additionally, L.A. Care described interventions it conducted to prevent further decline in performance on the measure.

2019–20 Recommendations

Based on the overall assessment of L.A. Care's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- ♦ Monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 3* PIP.
- ♦ Continue testing the health messaging campaign intervention from the 2017–19 *Diabetes Medication Adherence* Disparity PIP to determine its effectiveness for improving diabetes medication adherence in areas with low adherence rates.

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

Medi-Cal Managed Care External Quality Review Technical Report

Appendix Y: Performance Evaluation Report LIBERTY Dental Plan of California, Inc.

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare the federally required *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020*. The technical report provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities, including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

This appendix is specific to DHCS' contracted Medi-Cal dental managed care (DMC) plan, LIBERTY Dental Plan of California, Inc. ("LIBERTY Dental" or "the DMC plan"). The purpose of this appendix is to provide DMC plan-specific results of each activity and an assessment of the DMC plan's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to dental care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under the Medi-Cal Managed Care program (MCMC), and the term "member" refers to a person enrolled in a DMC plan. The review period for this DMC plan-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in LIBERTY Dental's 2020–21 plan-specific evaluation report. This DMC plan-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Dental Managed Care Plan Overview

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

LIBERTY Dental became operational as a DMC plan in Los Angeles County effective July 1, 2013 and in Sacramento County effective January 1, 2013. As of June 2020, LIBERTY Dental had 61,840 members in Los Angeles County and 167,457 in Sacramento County—for a total of 229,297 members.[1] This represents 17 percent of the DMC beneficiaries enrolled in Los Angeles County and 39 percent of DMC beneficiaries enrolled in Sacramento County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

Compliance Reviews Conducted

The following is a summary of the most recent review conducted for LIBERTY Dental. HSAG's compliance review summaries are based on final audit reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020). The description of the DHCS Audits and Investigations Division (A&I) Dental Audit may be found within the main section of this technical report.

Table 2.1 summarizes the results and status of the on-site A&I Dental Audit of LIBERTY Dental. A&I conducted the audit from May 13, 2019, through May 24, 2019. DHCS issued the audit report on November 25, 2019, and the final closeout letter on September 3, 2020. While DHCS conducted the on-site audit and issued the final closeout letter outside the review period for this report, HSAG includes the information from the audit because the report became available during the review period for this report and from the final closeout letter because it reflects full resolution of the findings from the May 2019 A&I Dental Audit.

Table 2.1—DHCS A&I Dental Audit of LIBERTY Dental
Audit Review Period: May 1, 2018, through April 30, 2019

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

Strengths—Compliance Reviews

In response to the CAP from the May 2019 A&I Dental Audit of LIBERTY Dental, the DMC plan submitted documentation to DHCS that resulted in the CAP being closed. The documentation summarized the changes LIBERTY Dental made to its policies and procedures to ensure the DMC plan is fully compliant with DHCS contract requirements in all four categories that A&I reviewed.

Opportunities for Improvement—Compliance Reviews

LIBERTY Dental has no outstanding findings from the May 2019 A&I Dental Audit; therefore, HSAG has no recommendations for the DMC plan in the area of compliance reviews.

3. Dental Managed Care Plan Performance Measures

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

Beginning with reporting year 2019, DHCS required DMC plans to submit both reporting units' audited performance measure rates reflecting measurement year data from the previous calendar year. In May 2020, LIBERTY Dental submitted to DHCS both reporting units' reporting year 2020 performance measure rates reflecting measurement year 2019 data (i.e., January 1, 2019, through December 31, 2019).

Performance Measure Results

Table 3.1 and Table 3.2 present LIBERTY Dental's reporting years 2019 and 2020 audited performance measure rates by domain for each DMC plan reporting unit. To allow HSAG to provide meaningful display of DMC plan performance, HSAG organized the performance measures according to health care areas that each measure affects (i.e., Access to Care and Preventive Care).

Table 3.1—Reporting Years 2019 and 2020 (Measurement Years 2018 and 2019) Dental Managed Care Plan Performance Measure Results
LIBERTY Dental—Los Angeles County

= Statistical testing result indicates that the reporting year 2020 rate is significantly better than the reporting year 2019 rate.

= Statistical testing result indicates that the reporting year 2020 rate is significantly worse than the reporting year 2019 rate.

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

Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

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

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Access to Care			
Annual Dental Visits—Ages 0–20 Years	39.69%	39.93%	0.24
Annual Dental Visits—Ages 21+ Years	21.26%	23.18%	1.93
Continuity of Care—Ages 0–20 Years	65.18%	68.00%	2.82
Continuity of Care—Ages 21+ Years	36.45%	41.09%	4.64
Exam/Oral Health Evaluations—Ages 0–20 Years	35.65%	36.17%	0.52
Exam/Oral Health Evaluations—Ages 21+ Years	17.20%	18.59%	1.39
General Anesthesia—Ages 0–20 Years	46.56%	39.82%	-6.74
General Anesthesia—Ages 21+ Years	33.85%	31.74%	-2.12
Overall Utilization of Dental Services—One Year—Ages 0–20 Years	44.25%	44.97%	0.72
Overall Utilization of Dental Services—One Year—Ages 21+ Years	21.23%	23.14%	1.91
Use of Dental Treatment Services—Ages 0–20 Years	17.32%	18.44%	1.13
Use of Dental Treatment Services—Ages 21+ Years	13.32%	14.67%	1.35
Usual Source of Care—Ages 0–20 Years	33.87%	32.70%	-1.16
Usual Source of Care—Ages 21+ Years	9.54%	11.12%	1.58
Preventive Care			
Preventive Services to Filling—Ages 0–20 Years	81.82%	83.30%	1.48
Preventive Services to Filling—Ages 21+ Years	31.06%	31.46%	0.40
Sealants to Restoration Ratio (Surfaces)—Ages 6–9 Years	5.81	5.47	-0.34

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Sealants to Restoration Ratio (Surfaces)—Ages 10–14 Years	2.13	1.83	-0.30
Treatment/Prevention of Caries—Ages 0–20 Years	24.53%	25.59%	1.06
Treatment/Prevention of Caries—Ages 21+ Years	7.27%	8.52%	1.25
Use of Preventive Services—Ages 0–20 Years	34.37%	34.84%	0.48
Use of Preventive Services—Ages 21+ Years	9.37%	10.77%	1.41
Use of Sealants—Ages 6–9 Years	13.24%	12.92%	-0.32
Use of Sealants—Ages 10–14 Years	6.33%	6.39%	0.07

Table 3.2—Reporting Years 2019 and 2020 (Measurement Years 2018 and 2019) Dental Managed Care Plan Performance Measure Results
LIBERTY Dental—Sacramento County

= Statistical testing result indicates that the reporting year 2020 rate is significantly better than the reporting year 2019 rate.

= Statistical testing result indicates that the reporting year 2020 rate is significantly worse than the reporting year 2019 rate.

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

Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

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

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Access to Care			
Annual Dental Visits—Ages 0–20 Years	42.38%	45.79%	3.41
Annual Dental Visits—Ages 21+ Years	22.57%	23.78%	1.21
Continuity of Care—Ages 0–20 Years	67.03%	71.52%	4.50
Continuity of Care—Ages 21+ Years	33.98%	39.82%	5.84
Exam/Oral Health Evaluations—Ages 0–20 Years	37.04%	40.78%	3.74
Exam/Oral Health Evaluations—Ages 21+ Years	16.51%	17.62%	1.11
General Anesthesia—Ages 0–20 Years	68.46%	63.12%	-5.35
General Anesthesia—Ages 21+ Years	34.32%	20.17%	-14.15
Overall Utilization of Dental Services—One Year—Ages 0–20 Years	49.42%	52.70%	3.28
Overall Utilization of Dental Services—One Year—Ages 21+ Years	24.86%	26.17%	1.31
Use of Dental Treatment Services—Ages 0–20 Years	25.03%	29.43%	4.41
Use of Dental Treatment Services—Ages 21+ Years	16.36%	17.24%	0.87
Usual Source of Care—Ages 0–20 Years	37.51%	39.54%	2.03
Usual Source of Care—Ages 21+ Years	12.32%	13.98%	1.66
Preventive Care			
Preventive Services to Filling—Ages 0–20 Years	84.05%	86.07%	2.03
Preventive Services to Filling—Ages 21+ Years	35.05%	40.14%	5.10
Sealants to Restoration Ratio (Surfaces)—Ages 6–9 Years	5.80	6.27	0.47

Measure	Reporting Year 2019 Rate	Reporting Year 2020 Rate	Reporting Years 2019–20 Rate Difference
Sealants to Restoration Ratio (Surfaces)—Ages 10–14 Years	2.22	2.14	-0.08
Treatment/Prevention of Caries—Ages 0–20 Years	30.09%	34.28%	4.19
Treatment/Prevention of Caries—Ages 21+ Years	8.66%	9.78%	1.11
Use of Preventive Services—Ages 0–20 Years	35.69%	39.32%	3.63
Use of Preventive Services—Ages 21+ Years	8.32%	9.46%	1.14
Use of Sealants—Ages 6–9 Years	17.01%	17.70%	0.69
Use of Sealants—Ages 10–14 Years	9.38%	9.63%	0.26

Strengths—Performance Measures

LIBERTY Dental had no measures with rates that declined significantly from reporting year 2019 to reporting year 2020; across both reporting units, 25 rates improved significantly from reporting year 2019 to reporting year 2020. Los Angeles County had nine measures with rates that improved significantly, and Sacramento County had 16 measures with rates that improved significantly.

Access to Care

Across both reporting units within the Access to Care health care area, 16 of 28 measure rates (57 percent) improved significantly from reporting year 2019 to reporting year 2020. These measures are listed below:

- *Annual Dental Visits—Ages 0–20 Years* in Sacramento County
- *Annual Dental Visits—Ages 21+ Years* in both reporting units
- Both *Continuity of Care* measures in both reporting units
- *Exam/Oral Health Evaluations—Ages 0–20 Years* in Sacramento County
- *Exam/Oral Health Evaluations—Ages 21+ Years* in both reporting units
- *Overall Utilization of Dental Services—One Year—Ages 0–20 Years* in Sacramento County
- *Overall Utilization of Dental Services—One Year—Ages 21+ Years* in both reporting units

- *Usual Source of Care—Ages 0–20 Years* in Sacramento County
- *Usual Source of Care—Ages 21+ Years* in both reporting units

Preventive Care

Across both reporting units within the Preventive Care health care area, nine of 20 measure rates (45 percent) improved significantly from reporting year 2019 to reporting year 2020. These measures are listed below:

- Both *Preventive Services to Filling* measures in Sacramento County
- Both *Treatment/Prevention of Caries* measures in both reporting units
- *Use of Preventive Services—Ages 0–20 Years* in Sacramento County
- *Use of Preventive Services—Ages 21+ Years* in both reporting units

Opportunities for Improvement—Performance Measures

Based on LIBERTY Dental's reporting year 2020 performance measure results, HSAG has no recommendations for the DMC plan in the area of performance measures.

4. Performance Improvement Projects

DHCS requires DMC plans to conduct two quality improvement projects (QIPs) per year. DMC plans must participate in a DHCS-established and facilitated statewide QIP as well as an individual QIP that aligns with a demonstrated area in need of improvement. For the statewide QIP, DMC plans must submit two reports annually—one intervention progress report to HSAG, and an annual QIP submission to DHCS. For the individual QIP, DMC plans must use HSAG's rapid-cycle performance improvement project (PIP) process. Because DHCS requires DMC plans to use HSAG's rapid-cycle PIP process for their individual QIPs, HSAG refers to DMC plans' individual QIPs as individual PIPs.

Statewide Quality Improvement Project

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

Based on the reporting requirements, LIBERTY Dental submitted its second annual intervention progress report to HSAG in January 2020. The DMC plan reported on identified barriers and interventions conducted as of December 31, 2019. In February 2020, HSAG provided feedback to LIBERTY Dental on the intervention progress report. HSAG noted that while LIBERTY Dental indicated that the interventions have been successful, the DMC plan did not meet the QIP goal.

HSAG suggested that LIBERTY Dental should:

- In the next annual intervention progress report, address all feedback and recommendations HSAG made in the last two consecutive annual intervention progress reports; and provide an updated causal/barrier analysis and key driver diagram.
- Revisit the causal/barrier analysis at least annually to reassess barriers; and in the next annual intervention progress report, provide a comprehensive list of the identified barriers ranked in order of priority.
- Link the interventions with identified barriers to ensure that the interventions will directly impact the QIP outcomes.
- Evaluate each intervention separately to determine the effectiveness of each intervention independently.

Individual Performance Improvement Project

Rapid-Cycle Performance Improvement Project Overview

The following is an overview of HSAG's rapid-cycle PIP process that DMC plans followed when conducting their individual PIPs.

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

The following provides an overview of the Rapid-Cycle PIP modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Individual Performance Improvement Project Results and Findings

Using its own DMC plan-specific data, LIBERTY Dental selected coordination of care for high-risk members as its 2019–21 individual PIP topic. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the DMC plan's module submissions for the 2019–21 individual PIP as well as validation findings from the review period.

During the review period of this report, HSAG validated modules 1 through 3 for the DMC plan's *Coordination of Care for High-Risk Members* PIP. Upon initial review of Module 1, HSAG determined that LIBERTY Dental met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of:
  - The SMART Aim statement.
  - The SMART Aim data collection methodology.
  - The SMART Aim run chart.

After receiving technical assistance from HSAG, LIBERTY Dental incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the DMC plan met all validation criteria for Module 1. LIBERTY Dental met all validation criteria for modules 2 and 3 in the DMC plan's initial submission.

Table 4.1 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the DMC plan's *Coordination of Care for High-Risk Members* PIP.

Table 4.1—LIBERTY Dental *Coordination of Care for High-Risk Members* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of deep cleanings or periodontal maintenance procedures completed among members who are living with diabetes and identified as high-risk	7.06%	12.00%

Table 4.2 presents a description of the intervention that LIBERTY Dental selected to test for its *Coordination of Care for High-Risk Members* PIP. The table also indicates the failure mode that the intervention aims to address.

Table 4.2—LIBERTY Dental *Coordination of Care for High-Risk Members* PIP Intervention Testing

Intervention	Failure Mode Addressed
Conduct text message outreach using a series of member engagement messages to inform members living with diabetes about the benefits of having deep cleanings or periodontal maintenance completed	Members do not receive any information about the importance of having a deep cleaning or periodontal maintenance completed when living with diabetes

While LIBERTY Dental advanced to the intervention testing phase, the PIP did not progress to the point where the DMC plan was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

LIBERTY Dental successfully completed the second annual intervention progress report for the *Preventive Services Utilization* statewide QIP. Additionally, using information gained from HSAG's PIP training, validation results, and technical assistance, LIBERTY Dental submitted all required documentation and met all criteria for the *Coordination of Care for High-Risk Members* individual PIP modules that the DMC plan completed during the review period.

Opportunities for Improvement—Performance Improvement Projects

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

5. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each DMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 DMC plan-specific evaluation report. Based on HSAG's assessment of LIBERTY Dental's delivery of quality, accessible, and timely care through the activities described in the DMC plan's 2018–19 DMC plan-specific evaluation report, HSAG included no recommendations in LIBERTY Dental's 2018–19 DMC plan-specific evaluation report. Therefore, LIBERTY Dental had no recommendations for which it was required to provide the DMC plan's self-reported actions.

2019–20 Recommendations

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

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

Medi-Cal Managed Care External Quality Review Technical Report

Appendix Z: Performance Evaluation Report Molina Healthcare of California

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Molina Healthcare of California ("Molina" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in Molina's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

In Riverside and San Bernardino counties, Molina is a full-scope MCP delivering services to its members as a commercial plan under the Two-Plan Model. Beneficiaries may enroll in Molina, the commercial plan, or in Inland Empire Health Plan, the alternative "local initiative".

In Sacramento and San Diego counties, Molina delivers services to its members under a Geographic Managed Care (GMC) model. The GMC model currently operates in the counties of San Diego and Sacramento. In this GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

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

- Aetna Better Health of California
- Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser NorCal

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

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

In Imperial County, Molina delivers services to its members under the Imperial model. Beneficiaries may enroll in Molina or California Health & Wellness Plan, the other CP.

Molina became operational in Riverside and San Bernardino counties to provide MCMC services effective December 1997. Molina expanded to Sacramento County in 2000 and San Diego County in 2005. The MCP began providing services in Imperial County effective November 1, 2013.

DHCS allows Molina to combine data for Riverside and San Bernardino counties for reporting purposes. For this report, Riverside and San Bernardino counties represent a single reporting unit. Sacramento County, San Diego County, and Imperial County each represent a single reporting unit.

Table 1.1 shows the number of members for Molina for each county, the percentage of beneficiaries in the county enrolled in Molina, and the MCP's total number of members as of June 2020.[1]

Table 1.1—Molina Enrollment as of June 2020

* Note that DHCS allows Molina to report Riverside and San Bernardino counties as a combined (i.e., single report unit) rate.

County	Enrollment as of June 2020	Percentage of Beneficiaries in the County Enrolled in Molina
Imperial	14,171	19%
Riverside*	82,679	12%
Sacramento	48,831	11%
San Bernardino*	66,763	10%
San Diego	209,033	30%
Total	421,477	

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Molina.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Molina. A&I conducted the audits from August 12, 2019, through August 23, 2019. DHCS issued the closeout letter on July 2, 2020, which is outside the review period for this report; however, HSAG includes the information from the letter because A&I conducted the on-site audits and issued the final audit reports during the review period for this report.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Molina
Audit Review Period: August 1, 2018, through July 31, 2019

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	Corrective action plan (CAP) imposed and findings in this category rectified.
Case Management and Coordination of Care	Yes	CAP imposed and findings in this category rectified.
Access and Availability of Care	Yes	CAP imposed and findings in this category rectified.
Member's Rights	No	No findings.
Quality Management	No	No findings.
Administrative and Organizational Capacity	No	No findings.
State Supported Services	No	No findings.

Follow-Up on 2018 A&I Medical Audit of Molina

A&I conducted a Medical Audit of Molina from July 30, 2018, through August 3, 2018, covering the review period of July 1, 2017, through June 30, 2018. HSAG provided a summary of the audit results and status in Molina's 2018–19 MCP-specific evaluation report. At the time of the 2018–19 MCP-specific evaluation report publication, Molina's CAP was in progress and under review by DHCS. A letter from DHCS dated May 27, 2020, stated that Molina provided DHCS with additional information regarding the CAP, and that DHCS had reviewed the information and closed the CAP. The letter indicated that DHCS would monitor the MCP's full implementation of the CAP during the subsequent audit.

Strengths—Compliance Reviews

In response to the CAPs from the 2018 and 2019 A&I Medical Audits of Molina, the MCP provided documentation to DHCS that resulted in the CAPs being closed. Molina's documentation reflected changes to policies and procedures to ensure the MCP is compliant with DHCS' standards within the Utilization Management, Case Management and Coordination of Care, and Access and Availability of Care categories.

Opportunities for Improvement—Compliance Reviews

Molina has no outstanding findings from the August 2019 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures Molina chose to report using one or both of these two options.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of Molina, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Molina Healthcare of California* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.16 for Molina's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.16

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 through Table 3.4 present the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Molina—Imperial County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	48.42%
Childhood Immunization Status—Combination 10	38.84%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	92.57%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	85.14%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	78.98%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	76.64%
Developmental Screening in the First Three Years of Life—Total	35.82%
Immunizations for Adolescents—Combination 2	32.14%

Measure	Reporting Year 2020 Rate
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	91.00%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	70.33%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.70%

Table 3.2—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Molina—Riverside/San Bernardino Counties

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	48.18%
Childhood Immunization Status—Combination 10	36.01%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	87.27%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	79.27%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	82.14%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	80.57%
Developmental Screening in the First Three Years of Life—Total	18.83%
Immunizations for Adolescents—Combination 2	38.44%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	83.45%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	39.66%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.59%

Table 3.3—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Molina—Sacramento County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	43.43%
Childhood Immunization Status—Combination 10	36.01%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	91.22%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	77.47%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	82.08%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	79.72%
Developmental Screening in the First Three Years of Life—Total	32.01%
Immunizations for Adolescents—Combination 2	41.85%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	80.54%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	46.89%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.10%

Table 3.4—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Molina—San Diego County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	52.80%
Childhood Immunization Status—Combination 10	48.23%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	95.42%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	86.84%

Measure	Reporting Year 2020 Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	89.49%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	87.98%
Developmental Screening in the First Three Years of Life—Total	44.86%
Immunizations for Adolescents—Combination 2	43.80%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	91.73%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	64.96%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.51%

Assessment of Improvement Plans—Children's Health Domain

In April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Molina conducted as part of its IP prior to April 2020.

The rate for the *Childhood Immunization Status—Combination 3* measure was below the minimum performance level in reporting year 2019 in both Riverside/San Bernardino and Sacramento counties. DHCS approved Molina to conduct a PIP to address the MCP's performance below the minimum performance level for this measure. Note that DHCS required MCPs to report rates for the *Childhood Immunization Status—Combination 10* measure in reporting year 2020 in place of the *Childhood Immunization Status—Combination 3* measure; therefore, Molina's PIP focuses on the *Childhood Immunization Status—Combination 10* measure. Because DHCS approved the MCP to conduct a PIP, DHCS did not require the MCP to conduct additional quality improvement activities related to this measure. HSAG includes a summary of Molina's progress on the *Childhood Immunization Status—Combination 10* PIP in Section 5 of this report ("Performance Improvement Projects").

DHCS did not hold MCPs accountable to meet the minimum performance level for the *Childhood Immunization Status—Combination 10* measure in reporting year 2020; therefore, HSAG makes no assessment of Molina's performance related to this measure.

Women's Health Domain

Table 3.5 through Table 3.8 present the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.5—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Molina—Imperial County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	57.35%
Cervical Cancer Screening	64.23%
Chlamydia Screening in Women—Ages 16–20 Years	54.25%
Chlamydia Screening in Women—Ages 21–24 Years	70.11%
Chlamydia Screening in Women—Total	62.91%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	12.12%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	26.60%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.85%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.65%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	15.38%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	43.79%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	S
Prenatal and Postpartum Care—Postpartum Care	72.61%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	95.65%

Table 3.6—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Molina—Riverside/San Bernardino Counties

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	57.16%
Cervical Cancer Screening	60.34%
Chlamydia Screening in Women—Ages 16–20 Years	58.42%
Chlamydia Screening in Women—Ages 21–24 Years	66.02%
Chlamydia Screening in Women—Total	61.71%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	10.90%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	19.67%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	1.63%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	2.68%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.35%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	29.47%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	32.95%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	5.36%
Prenatal and Postpartum Care—Postpartum Care	68.37%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	94.65%

Table 3.7—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Molina—Sacramento County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	50.06%
Cervical Cancer Screening	59.12%
Chlamydia Screening in Women—Ages 16–20 Years	66.67%
Chlamydia Screening in Women—Ages 21–24 Years	69.06%
Chlamydia Screening in Women—Total	67.82%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	13.27%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	21.23%

Measure	Reporting Year 2020 Rate
Contraceptive Care—All Women—LARC—Ages 15–20 Years	1.87%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	3.90%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	4.02%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	30.73%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	9.93%
Prenatal and Postpartum Care—Postpartum Care	68.86%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	96.84%

Table 3.8—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Molina—San Diego County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	64.65%
Cervical Cancer Screening	63.75%
Chlamydia Screening in Women—Ages 16–20 Years	62.83%

Measure	Reporting Year 2020 Rate
Chlamydia Screening in Women—Ages 21–24 Years	70.44%
Chlamydia Screening in Women—Total	66.59%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	16.98%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	28.12%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.88%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.45%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	9.22%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	29.21%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	35.67%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.03%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	10.67%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	10.78%
Prenatal and Postpartum Care—Postpartum Care	79.08%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	96.11%

Behavioral Health Domain

Table 3.9 through Table 3.12 present the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.9—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Molina—Imperial County

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	57.14%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	38.66%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	29.73%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	4.85%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	2.29%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Table 3.10—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Molina—Riverside/San Bernardino Counties

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

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	54.55%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	36.48%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	33.79%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	36.37%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	20.30%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	24.94%

Table 3.11—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Molina—Sacramento County

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

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	51.31%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	34.85%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	21.84%

Measure	Reporting Year 2020 Rate
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	8.99%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	4.25%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	5.17%

Table 3.12—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Molina—San Diego County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	59.74%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	44.04%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	40.10%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	42.50%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	21.52%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	15.39%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	15.07%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.13 through Table 3.16 present the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.13—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Molina—Imperial County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	94.65%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	46.90
Asthma Medication Ratio—Total	60.00%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	37.96%
Comprehensive Diabetes Care—HbA1c Testing—Total	91.24%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	9.95%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	71.05%
HIV Viral Load Suppression—Ages 18–64 Years	S
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.85%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.21%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.85
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	7.52%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.14—Acute and Chronic Disease Management Domain Reporting Year 2020 Performance Measure Results Molina—Riverside/San Bernardino Counties

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	92.94%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	40.43
Asthma Medication Ratio—Total	53.75%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	35.52%
Comprehensive Diabetes Care—HbA1c Testing—Total	89.78%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	12.55%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	61.31%
HIV Viral Load Suppression—Ages 18–64 Years	S
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	6.37%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.40%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.68
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	2.91%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.15—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Molina—Sacramento County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	92.94%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	57.80
Asthma Medication Ratio—Total	54.06%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	44.28%
Comprehensive Diabetes Care—HbA1c Testing—Total	83.45%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	7.07%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	57.18%
HIV Viral Load Suppression—Ages 18–64 Years	51.16%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.99%
Plan All-Cause Readmissions—Expected Readmissions—Total	10.64%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.85
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	6.13%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.16—Acute and Chronic Disease Management Domain Reporting Year 2020 Performance Measure Results Molina—San Diego County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	95.13%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	44.18
Asthma Medication Ratio—Total	57.85%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	33.33%
Comprehensive Diabetes Care—HbA1c Testing—Total	91.48%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	8.88%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	71.78%
HIV Viral Load Suppression—Ages 18–64 Years	22.66%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.09%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.53%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.85
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	3.87%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	0.00%

Assessment of Improvement Plans—Acute and Chronic Disease Management Domain

As previously stated, in April 2020, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Molina conducted as part of its IP prior to April 2020.

Based on reporting year 2019 performance measure results, DHCS required Molina to submit IPs for the following measures within the Acute and Chronic Disease Management domain:

- *Asthma Medication Ratio—Total* in Riverside/San Bernardino and Sacramento counties
- *Comprehensive Diabetes Care—HbA1c Testing—Total* in Sacramento County

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of Molina's performance related to measures within the Acute and Chronic Disease Management domain for which the MCP conducted PDSA cycles or a PIP.

Asthma Medication Ratio—Total

DHCS approved Molina to conduct PDSA cycles to address the MCP's performance below the minimum performance level for the *Asthma Medication Ratio—Total* measure in Riverside/San Bernardino and Sacramento counties.

Molina collaborated with a provider group to test whether 90-day prescription fills for asthma controller medications for members identified through gap-in-care reports would result in improvement in the *Asthma Medication Ratio—Total* measure rate. The MCP noted that the biggest barrier to the success of the intervention was missing or inaccurate member contact information. To address this barrier, Molina's outreach coordinator attempted to find accurate member contact information through various MCP systems, including case management and pharmacy.

Comprehensive Diabetes Care—HbA1c Testing—Total

DHCS approved Molina to conduct a PIP to address the MCP's performance below the minimum performance level in Sacramento County for the *Comprehensive Diabetes Care—HbA1c Testing—Total* measure. Because DHCS approved the MCP to conduct a PIP, DHCS did not require the MCP to conduct additional quality improvement activities related to this measure. HSAG includes a summary of Molina's progress on the *Diabetes Testing* Health Equity PIP in Section 5 of this report ("Performance Improvement Projects").

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, Molina will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.17 through Table 3.20 present the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.17—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Molina—Imperial County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	82.85	44.32	Not Tested	46.90
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	92.54%	Not Comparable	92.57%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	91.18%	84.95%	6.23	85.14%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	NA	78.66%	Not Comparable	78.98%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	72.50%	76.76%	-4.26	76.64%
*Plan All-Cause Readmissions—Total***	NA	7.57%	Not Comparable	7.85%

Table 3.18—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Molina—Riverside/San Bernardino Counties

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	69.18	38.74	Not Tested	40.43
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	87.46%	Not Comparable	87.27%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	83.23%	79.20%	4.03	79.27%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	84.89%	82.06%	2.83	82.14%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	81.88%	80.52%	1.36	80.57%
*Plan All-Cause Readmissions—Total***	9.63%	5.34%	4.29	6.37%

Table 3.19—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Molina—Sacramento County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	93.34	53.07	Not Tested	57.80
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	91.38%	Not Comparable	91.22%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	73.26%	77.58%	-4.32	77.47%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	86.33%	81.91%	4.42	82.08%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	79.91%	79.71%	0.20	79.72%
*Plan All-Cause Readmissions—Total***	10.36%	8.00%	2.36	8.99%

Table 3.20—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Molina—San Diego County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	74.74	42.01	Not Tested	44.18
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	95.41%	Not Comparable	95.42%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	91.73%	86.73%	5.00	86.84%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	94.76%	89.33%	5.43	89.49%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	91.91%	87.86%	4.05	87.98%
*Plan All-Cause Readmissions—Total***	9.86%	7.46%	2.40	8.09%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that Molina stratified by the SPD and non-SPD populations and for which HSAG could compare reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results:

- The reporting year 2020 SPD rates were significantly better than the reporting year 2020 non-SPD rates for the *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years*, *Ages 7–11 Years*, and *Ages 12–19 Years* measures in San Diego County.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020 in Riverside/San Bernardino and San Diego counties. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to Molina's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that Molina report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 and Table 4.2 present the reporting year 2020 rates for each required MLTSSP performance measure. Table 4.1 and Table 4.2 present reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 4.1—Reporting Year 2020 MLTSSP Performance Measure Results Molina—Riverside/San Bernardino Counties

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	76.49
*Plan All-Cause Readmissions—Observed Readmissions—Total***	11.84%
Plan All-Cause Readmissions—Expected Readmissions—Total	13.32%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.89

Table 4.2—Reporting Year 2020 MLTSSP Performance Measure Results Molina—San Diego County

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

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

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	74.08
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.03%
Plan All-Cause Readmissions—Expected Readmissions—Total	12.05%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.83

5. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, Molina submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, Molina initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, Molina identified postpartum care among African-American members residing in Riverside and San Bernardino counties as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure results reported by the MCP for its *Postpartum Care* Disparity PIP.

Table 5.1—Molina *Postpartum Care* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of postpartum visits among African-American women residing in Riverside and San Bernardino counties	29.8 %	40.4%	Yes

Table 5.2 presents a description of the intervention that Molina tested for its *Postpartum Care* Disparity PIP. The table also indicates the key drivers that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.2—Molina *Postpartum Care* Disparity PIP Intervention Testing Results

Intervention	Key Drivers Addressed	Adopt, Adapt, Abandon, or Continue Testing
Based on ethnicity and geographic location information captured from delivery data, implement care coordination and outreach efforts to provide education on the importance of the postpartum visit and assistance with scheduling a timely postpartum visit	♦ Socioeconomic factors such as social support, cultural beliefs, and transportation ♦ Access to childcare in order to seek medical attention needed during the postpartum phase ♦ A history of previous pregnancies and postpartum care without complications	Adopt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Molina's *Postpartum Care* Disparity PIP. Molina documented in the modules that it tested the care coordination and outreach intervention from October 2018 through June 2019. The MCP determined that the intervention was effective and decided to adopt the intervention. Based on the SMART Aim run chart, Molina met the SMART Aim goal prior to beginning intervention testing; however, the SMART Aim measure rate continued to improve during the intervention testing phase, with the MCP achieving the highest SMART Aim measure rate in June 2019.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned Molina's *Postpartum Care* Disparity PIP a final confidence level of *Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on Molina's reporting year 2017 performance measure results, the MCP selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure results as reported by the MCP for its *Childhood Immunization Status—Combination 3* PIP.

Table 5.3—Molina *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of *Childhood Immunization Status—Combination 3* measure at Clinic A[6]	51.9%	69.6%	No

Table 5.4 presents a description of the intervention that Molina tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the key drivers and failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.4—Molina *Childhood Immunization Status—Combination 3* PIP Intervention Testing Results

Intervention	Key Drivers and Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide gift cards for Clinic A to disseminate directly to members once they complete the *Childhood Immunization Status—Combination 3* vaccination series	♦ Parents lack education or awareness of an immunization schedule ♦ Parents do not start vaccinating members in a timely manner ♦ Parents misplace members' immunization record card	Abandon

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Molina's *Childhood Immunization Status—Combination 3* PIP. Molina documented in the modules that it began testing the member incentive intervention in July 2018. The MCP provided gift cards to the provider partner to directly award members once they completed the *Childhood Immunization Status—Combination 3* measure series. In January 2019, Molina's contract with the provider partner terminated, and while the MCP expected that members would choose to stay at the same clinic site for primary care services, many members transferred to new providers at other locations. This transition resulted in a dramatic reduction in the SMART Aim measure denominator; therefore, Molina decided to abandon the intervention. The MCP did not achieve the SMART Aim goal.

[6] Clinic name removed for confidentiality.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned Molina's *Childhood Immunization Status—Combination 3* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, Molina identified diabetes testing as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Diabetes Testing* Health Equity PIP. Upon initial review of the modules, HSAG determined that Molina met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- ♦ Including all required components of the SMART Aim data collection methodology.
- ♦ Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- ♦ Linking logically the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.

After receiving technical assistance from HSAG, Molina incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. Molina was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, Molina selected childhood immunizations as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Childhood Immunization Status—Combination 10* PIP. Upon initial review of the modules, HSAG determined that Molina met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- ♦ Supporting the narrowed focus with data.

- Including all required components of the SMART Aim data collection methodology.
- Including all required components of the SMART Aim.
- Including all required components of the SMART Aim run chart.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.

After receiving technical assistance from HSAG, Molina incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. Molina was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Molina achieved the SMART Aim goal for the 2017–19 *Postpartum Care* Disparity PIP, and some of the quality improvement activities could be linked to the demonstrated improvement. Based on its assessment, HSAG assigned the 2017–19 *Postpartum Care* Disparity PIP a final confidence level of *Confidence*. Additionally, upon completion of the 2017–19 *Postpartum Care* Disparity PIP, Molina identified an intervention that it can adopt to improve postpartum care visit rates among its members.

Opportunities for Improvement—Performance Improvement Projects

Molina has the opportunity to continue monitoring the adopted intervention and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Postpartum Care* Disparity PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes. Additionally, Molina has the opportunity to apply the lessons learned from the 2017–19 PIPs to facilitate improvement for future PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

Molina submitted the MCP's PNA report to DHCS on June 30, 2020, and DHCS notified the MCP via email on July 28, 2020, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from Molina's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of Molina's self-reported actions.

Table 8.1—Molina's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP fully resolves all findings from the July 30, 2018, through August 3, 2018, Medical and State Supported Services Audits.	CAPs for all deficiencies identified during the July 30, 2018, through August 3, 2018, Medical and State Supported Services Audits were developed and implemented prior to receipt of the May 15, 2019, DHCS Audit Report. CAP responses were provided to DHCS for review on June 27, 2019, with additional CAP information submitted December 6, 2019. All CAP responses except one were accepted by DHCS on December 6, 2019. Additional information was submitted to DHCS on April 8, 2020, and May 20, 2020, for the final open deficiency. On May 27, 2020, DHCS notified Molina that the CAP was closed.
2. Determine the causes for the rates for the following measures being below the minimum performance levels in reporting year 2019 and identify strategies to address the causes:	
♦ *Asthma Medication Ratio* measure in Riverside/San Bernardino and Sacramento counties (Note that the rates for this measure declined significantly from reporting year 2017 to	NCQA HEDIS specification changes made in reporting year 2019 caused the *Asthma Medication Ratio* rates to fall below the minimum performance level in Riverside/San Bernardino and Sacramento counties. These specification changes resulted in members' eligibility for inclusion in this measure denominator after having a single emergency room or inpatient event.

2018–19 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
reporting year 2018 for both reporting units.)	Barriers identified included assigned primary care providers' (PCPs') lack of awareness of an emergency room or inpatient event, with a subsequent missed opportunity for appropriate asthma medication prescription. Molina implemented the following strategies to address these causes/barriers: ♦ Piloted an *Asthma Medication Ratio* roster intervention identifying members in need of asthma medication review with participating independent practice associations (IPAs). ♦ Expanded the *Asthma Medication Ratio* roster intervention to all high-volume providers, with the addition of a peer-to-peer educational letter from Molina's chief medical officer (CMO) to empower PCPs to leverage telehealth options and focus on educating members about the importance of using controller medications. Additionally, Molina identified the importance of front office staff members assisting with tracking members with asthma to ensure they stay up to date on their medications. ♦ In 2019, the *Asthma Medication Ratio* measure was added to Molina's HEDIS Pay-for-Performance (P4P) program. Providers with a final *Asthma Medication Ratio* measure rate at the 50th percentile receive $50 for each compliant eligible member. Providers with a final *Asthma Medication Ratio* measure rate at the 25th percentile receive $25 for each compliant eligible member. If a provider does not achieve the 25th percentile, no payment is issued.
♦ *Childhood Immunization Status—Combination 3* measure in Riverside/San Bernardino and Sacramento counties, building on successes and applying lessons learned from the MCP's *Childhood Immunization Status—*	Retirement of the Child Health and Disability Prevention (CHDP) Program PM 160 Form contributed to the *Childhood Immunization Status—Combination 3* measure rates falling below the minimum performance levels in Riverside/San Bernardino and Sacramento counties. PM 160 reporting was the primary source of supplemental data for the *Childhood Immunization Status—Combination 3* measure and served as an

2018–19 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
Combination 3 PIP. (The rates for this measure have been below the minimum performance levels for more than three consecutive years in Sacramento County.)	assurance that any HEDIS quality information missing from encounter or claim data reporting was captured. Barriers identified included: ♦ Provider lack of knowledge regarding the new process of reporting Current Procedural Terminology (CPT) and International Classification of Diseases, Tenth Revision (ICD-10) codes in claims and encounter submissions to capture information typically submitted in a PM 160 form. This resulted in a missed opportunity for reporting accurate *Childhood Immunization Status—Combination 3* measure data. ♦ Providers' inconsistency with entering *Childhood Immunization Status—Combination 3* measure data in the California Immunization Registry. ♦ NCQA HEDIS technical specification changes removed Pneumococcal Vaccine (PCV) compliant CPT code 90669 which reduced the administrative rate for the *Childhood Immunization Status—Combination 3* measure. This required medical record abstraction to obtain the PCV data. Molina implemented the following strategies to address these causes/barriers: ♦ Created provider educational documents on proper CPT and CVX (vaccine administered) code submission as well as educational points on the importance of providers utilizing the California Immunization Registry to improve member compliance. ♦ Conducted year-round medical record abstraction for *Childhood Immunization Status—Combination 3* measure eligible members to improve administrative data compliance. ♦ The *Childhood Immunization Status—Combination 3* measure continued as a HEDIS P4P measure for Riverside/San Bernardino and Sacramento counties. In 2019 the *Childhood Immunization Status—Combination 3* incentive in Riverside/San Bernardino counties increased from $100 to $300.

2018–19 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ Based on successes noted in the 2018 *Childhood Immunization Status—Combination 3* PIP, as well as lessons learned (need for ongoing close partnership and frequent reporting), Molina partnered with its largest IPA in Riverside/San Bernardino counties and launched a Pediatric Practice Transformation Initiative, which focused on improving childhood immunizations. ■ Molina trained the IPA quality team in principles of practice transformation to impact 30 practices. ■ Molina developed cobranded educational materials. ■ The IPA CMO leveraged provider participation. ■ Molina held monthly sessions with the clinic and monthly follow-ups with the IPA to review progress/barriers.
♦ *Comprehensive Diabetes Care—HbA1c Testing* in Sacramento County	Molina conducted a causal and barrier analysis of the reporting year 2019 *Comprehensive Diabetes Care—HbA1c Testing* measure rate reduction in Sacramento County. Findings resulted in the selection of this measure as the topic for Molina's 2019–20 Health Disparity PIP: ♦ Molina's Medi-Cal population in Sacramento County is reported at 73.9 percent non-white. Many are experiencing a low social and/or economic status. This population is less likely to access health care and has the most geographically related disparity challenges for compliance. Molina implemented the following strategies to address these causes/barriers: ♦ Molina partnered with Care Connections nurse practitioners (NPs) in Sacramento County to complete a high volume of monthly in-home diabetic visits. The NP includes the HbA1c test collection during the home visit. This program was selected as it previously demonstrated sustained improvement in reducing health disparities for postpartum care.

2018–19 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ Monthly gap-in-care reports were provided to Care Connections NPs to ensure they would target at-risk members.
3. Determine the causes for the MCP's performance for the following measures in Sacramento County declining significantly from reporting year 2018 to reporting year 2019 and identify strategies to address the causes:	
♦ *Breast Cancer Screening*	Molina conducted a causal and barrier analysis of the 4.01 percentage point decline from reporting year 2018 (63.21 percent) to reporting year 2019 (59.20 percent) for the *Breast Cancer Screening* measure in Sacramento County. The reporting year 2019 *Breast Cancer Screening* measure rate remained above the NCQA 50th percentile. Data analysis indicated: ♦ A significant drop in administrative rate reporting for measurement year 2018 from the highest-volume Sacramento-based medical group, with approximately 90 percent of Molina Sacramento membership. The group ultimately terminated its contract with Molina in January 2019. Molina implemented the following strategies to address these causes/barriers: ♦ In 2019 and 2020, monthly *Breast Cancer Screening* gap-in-care reports were distributed to all high-volume groups in Sacramento County. The MCP pulled a report showing members who are non-compliant with breast cancer screening in accordance with the NCQA technical specifications for the measure. The purpose of the gap-in-care report is to inform our providers of their patients that need a breast cancer screening. ♦ To emphasize the gap-in-care reports, Molina held monthly meetings with our largest IPAs to help drive the priority of members who should be targeted and review the gap-in-care reports. These meetings were intended to inform the providers of their members needing services, and it was important to assist with the transition of care that was caused by the termination of one of the medical groups and the mass-member transfer that resulted.

2018–19 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	♦ Molina also met with numerous high-volume provider offices, to review gap-in-care reports in a similar manner as the IPA meetings.
♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*	Molina conducted a causal and barrier analysis of the 8.03 percentage point increase from reporting year 2018 (34.31 percent) to reporting year 2019 (42.34 percent) for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure in Sacramento County. Findings included: ♦ There was also a rate reduction noted in the reporting year 2019 *Comprehensive Diabetes Care—HbA1c Testing* measure in Sacramento County. NCQA technical specifications dictate that if no HbA1c test result is documented for a member, the member defaults into the subcategory of HbA1c Poor Control (>9.0 Percent). ♦ The highest-volume Sacramento-based medical group, with approximately 90 percent of Molina Sacramento membership, had a significant decline for the rate for the *Comprehensive Diabetes Care—HbA1c Testing* measure and a significant increase in the rate for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure in measurement year 2018. The group ultimately terminated its contract with Molina in January 2019. Molina implemented the following strategies to address these causes/barriers: ♦ Molina partnered with Care Connections NPs in Sacramento County to complete a high volume of in-home diabetic visits monthly. The NP includes the HbA1c test collection during the home visit. HbA1c results are then reported to the member's PCP for follow-up diabetes care and medication management. ♦ In 2019 and 2020 monthly gap-in-care reports were provided to Care Connections to ensure the NPs would target at-risk members.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Molina's self-reported actions in Table 8.1 and determined that Molina adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. Molina described in detail actions taken during the review period, results from the MCP's assessment of declining performance, barriers identified, and steps the MCP plans to take moving forward. Molina also described specific interventions it implemented to address the identified barriers and improve performance to above the minimum performance levels or prevent further decline in performance.

2019–20 Recommendations

Based on the overall assessment of Molina's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Continue monitoring the adopted intervention and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 *Postpartum Care* Disparity PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.
- Apply the lessons learned from the 2017–19 PIPs to facilitate improvement for future PIPs.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix AA:
Performance Evaluation Report
Partnership HealthPlan of California
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted MCP, Partnership HealthPlan of California ("Partnership" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in Partnership's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific

activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

Partnership is a full-scope MCP delivering services to its members in the County Organized Health System model.

Partnership became operational to provide MCMC services in Solano County effective May 1994, Napa County in March 1998, in Yolo County in March 2001, in Sonoma County in October 2009, and in Marin and Mendocino counties in July 2011. As part of the expansion authority under Section 1115 of the Social Security Act, MCMC expanded into several rural northern counties of California in 2013. Under the expansion, Partnership contracted with DHCS to provide MCMC services in Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties beginning November 1, 2013.

Table 1.1 shows Partnership's enrollment for each county and the MCP's total number of members as of June 2020.[1]

Table 1.1—Partnership Enrollment as of June 2020

County	Enrollment as of June 2020
Del Norte	11,228
Humboldt	52,786
Lake	29,812
Lassen	7,339
Marin	39,042
Mendocino	35,256
Modoc	3,578
Napa	28,590
Shasta	59,315
Siskiyou	16,829
Solano	107,822

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

County	Enrollment as of June 2020
Sonoma	103,209
Trinity	4,542
Yolo	50,949
Total	550,297

For reporting purposes, DHCS allows Partnership to combine data from multiple counties into regions to make up four single reporting units. Partnership's regions are as follows:

- **Northeast**—Lassen, Modoc, Shasta, Siskiyou, and Trinity counties
- **Northwest**—Del Norte and Humboldt counties
- **Southeast**—Napa, Solano, and Yolo counties
- **Southwest**—Lake, Marin, Mendocino, and Sonoma counties

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for Partnership. HSAG's compliance review summaries are based on final audit reports issued on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of Partnership. A&I conducted the audits from February 3, 2020, through February 14, 2020.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of Partnership Audit Review Period: January 1, 2019, through December 31, 2019

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

Strengths—Compliance Reviews

A&I identified no findings during the February 2020 Medical and State Supported Services Audits of Partnership.

Opportunities for Improvement—Compliance Reviews

Partnership had no findings from the February 2020 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Partnership chose to report all hybrid measures according to the reporting year 2020 measure specifications using measurement year 2019 data.

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a corrective action plan (CAP) for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- ♦ Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- ♦ Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of Partnership, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Partnership HealthPlan of California* contains the detailed findings and recommendations from the audit.

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

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.16 for Partnership's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.16:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Results—Children's Health Domain

Table 3.1 through Table 3.4 present the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	43.07%
Childhood Immunization Status—Combination 10	15.33%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	92.43%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	83.43%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	82.75%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	81.77%
Developmental Screening in the First Three Years of Life—Total	1.99%
Immunizations for Adolescents—Combination 2	18.98%

Measure	Reporting Year 2020 Rate
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	83.94%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	47.69%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.94%

Table 3.2—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Partnership—Northwest (Del Norte and Humboldt Counties)

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	43.80%
Childhood Immunization Status—Combination 10	20.19%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	94.40%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	85.25%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	85.09%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	84.60%
Developmental Screening in the First Three Years of Life—Total	2.77%
Immunizations for Adolescents—Combination 2	30.90%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	79.32%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	38.93%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.05%

Table 3.3—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Partnership—Southeast (Napa, Solano, and Yolo Counties)

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	55.23%
Childhood Immunization Status—Combination 10	43.31%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	94.35%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	86.70%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	87.85%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	87.39%
Developmental Screening in the First Three Years of Life—Total	32.79%
Immunizations for Adolescents—Combination 2	52.31%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	89.78%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	51.34%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	80.28%

Table 3.4—Children's Health Domain
Reporting Year 2020 Performance Measure Results
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	52.80%
Childhood Immunization Status—Combination 10	43.07%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	95.31%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	89.28%

Measure	Reporting Year 2020 Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	89.60%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	89.45%
Developmental Screening in the First Three Years of Life—Total	34.80%
Immunizations for Adolescents—Combination 2	46.47%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	84.91%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	62.53%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	79.44%

Assessment of Corrective Action Plan—Children's Health Domain

In April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Partnership conducted as part of its CAP prior to April 2020.

Based on reporting year 2019 performance measure results, the following measures within the Children's Health Domain were included in Partnership's CAP for the Northeast and Northwest regions:

- *Childhood Immunization Status—Combination 3*
  - Note that DHCS required MCPs to report rates for the *Childhood Immunization Status—Combination 10* measure in reporting year 2020 in place of the *Childhood Immunization Status—Combination 3* measure; therefore, Partnership's CAP quality improvement activities focused on the *Childhood Immunization Status—Combination 10* measure.
- *Immunizations for Adolescents—Combination 2*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of Partnership's performance related to measures within the Children's Health domain for which the MCP conducted PDSA cycles or a PIP.

Childhood Immunizations

DHCS approved Partnership to conduct PDSA cycles to address the rates for the *Childhood Immunization Status—Combination 3* measure being below the minimum performance level in the Northeast and Northwest regions in reporting year 2019. Partnership conducted one PDSA cycle to test whether telephonic outreach to members in need of recommended immunization doses before turning 1 year old would increase the likelihood that these members would be compliant with all recommended doses by 2 years of age. The MCP reported learning that members may receive up to three influenza doses prior to their second birthday.

Adolescent Immunizations

DHCS approved Partnership to conduct PDSA cycles to address the rates for the *Immunizations for Adolescents—Combination 2* measure being below the minimum performance level in the Northeast and Northwest regions in reporting year 2019. Partnership conducted one PDSA cycle to test whether telephonic member outreach based on the MCP's dosage report, which was prioritized by the immunization urgency, and offering a member incentive would improve the *Immunizations for Adolescents—Combination 2* measure rate. Partnership reported that the clinic partner's internal process did not allow providers to administer immunizations to members who were overdue for a well-child visit and that the clinic is working to eliminate this barrier.

Well-Child Visits

The rates for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure were below the minimum performance level in the Northeast and Northwest regions in reporting year 2019. DHCS approved Partnership to conduct a *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP in place of conducting PDSA cycles to improve the MCP's performance on this measure. HSAG includes a summary of Partnership's progress on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP in Section 4 of this report ("Performance Improvement Projects").

Women's Health Domain

Results—Women's Health Domain

Table 3.5 through Table 3.8 present the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.5—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	55.13%
Cervical Cancer Screening	55.96%
Chlamydia Screening in Women—Ages 16–20 Years	50.85%
Chlamydia Screening in Women—Ages 21–24 Years	60.10%
Chlamydia Screening in Women—Total	54.96%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	30.93%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	25.50%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	5.38%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.88%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.32%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	34.02%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	32.62%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	11.34%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	7.42%

Measure	Reporting Year 2020 Rate
Prenatal and Postpartum Care—Postpartum Care	77.86%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	92.94%

Table 3.6—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Partnership—Northwest (Del Norte and Humboldt Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	47.96%
Cervical Cancer Screening	50.85%
Chlamydia Screening in Women—Ages 16–20 Years	53.48%
Chlamydia Screening in Women—Ages 21–24 Years	62.31%
Chlamydia Screening in Women—Total	57.82%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	30.84%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	24.95%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	4.91%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.69%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	0.00%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	6.56%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	38.98%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	38.59%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	0.00%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	11.72%
Prenatal and Postpartum Care—Postpartum Care	87.10%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.97%

Table 3.7—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Partnership—Southeast (Napa, Solano, and Yolo Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	64.54%
Cervical Cancer Screening	67.40%
Chlamydia Screening in Women—Ages 16–20 Years	66.47%
Chlamydia Screening in Women—Ages 21–24 Years	74.49%
Chlamydia Screening in Women—Total	70.13%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	21.22%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	30.74%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	4.00%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.75%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	11.81%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	38.71%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	45.57%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.18%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	19.89%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	19.30%
Prenatal and Postpartum Care—Postpartum Care	78.10%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	94.89%

Table 3.8—Women's Health Domain
Reporting Year 2020 Performance Measure Results
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	60.26%
Cervical Cancer Screening	68.37%
Chlamydia Screening in Women—Ages 16–20 Years	62.06%
Chlamydia Screening in Women—Ages 21–24 Years	67.90%
Chlamydia Screening in Women—Total	64.53%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	24.96%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	31.18%

Measure	Reporting Year 2020 Rate
Contraceptive Care—All Women—LARC—Ages 15–20 Years	4.86%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	7.29%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	10.20%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	54.43%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	46.92%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	1.72%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	31.65%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	21.59%
Prenatal and Postpartum Care—Postpartum Care	86.86%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	95.38%

Assessment of Corrective Action Plan—Women's Health Domain

In April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Partnership conducted as part of its CAP prior to April 2020.

DHCS approved Partnership to conduct PDSA cycles to address the rates for the *Breast Cancer Screening—Total* measure being below the minimum performance level in the Northwest Region in reporting year 2019. Partnership conducted two PDSA cycles with a clinic partner to test whether members would be motivated after receiving an outreach call from the clinic to obtain their mammogram through a mobile mammography clinic. Partnership indicated that the only barrier identified by the clinic was that the clinic staff members had difficulty completing the outreach calls. The clinic resolved the barrier by assigning one staff member the responsibility for conducting the calls, which resulted in this staff member taking ownership of the outreach efforts.

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of Partnership's performance related to the *Breast Cancer Screening—Total* measure.

Behavioral Health Domain

Table 3.9 through Table 3.12 present the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.9—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	56.81%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	39.93%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	31.22%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	33.80%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	1.56%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.64%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Table 3.10—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Partnership—Northwest (Del Norte and Humboldt Counties)

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	59.60%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	42.60%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	34.51%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	51.61%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	S
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.12%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.00%

Table 3.11—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Partnership—Southeast (Napa, Solano, and Yolo Counties)

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	62.02%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	43.16%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	23.75%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	23.85%

Measure	Reporting Year 2020 Rate
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	6.70%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	8.53%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	5.27%

Table 3.12—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	58.24%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	40.42%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	28.46%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	27.52%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	3.56%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	5.82%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	3.17%

Acute and Chronic Disease Management Domain

Results—Acute and Chronic Disease Management Domain

Table 3.13 through Table 3.16 present the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.13—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	94.40%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	53.55
Asthma Medication Ratio—Total	52.23%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	36.48%
Comprehensive Diabetes Care—HbA1c Testing—Total	90.32%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	14.46%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	61.70%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.49%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.78%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.77
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.30%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.14—Acute and Chronic Disease Management Domain Reporting Year 2020 Performance Measure Results Partnership—Northwest (Del Norte and Humboldt Counties)

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	96.35%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	41.58
Asthma Medication Ratio—Total	51.85%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	32.85%
Comprehensive Diabetes Care—HbA1c Testing—Total	90.75%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	16.09%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	61.73%
HIV Viral Load Suppression—Ages 18–64 Years	0.00%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.26%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.88%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.74
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.87%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Table 3.15—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Partnership—Southeast (Napa, Solano, and Yolo Counties)

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	94.16%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	48.93
Asthma Medication Ratio—Total	71.26%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	31.30%
Comprehensive Diabetes Care—HbA1c Testing—Total	90.71%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	7.79%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	65.89%
HIV Viral Load Suppression—Ages 18–64 Years	S
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	7.85%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.89%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.79
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	4.39%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S

Table 3.16—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	93.92%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	47.04
Asthma Medication Ratio—Total	63.86%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	32.52%
Comprehensive Diabetes Care—HbA1c Testing—Total	91.93%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	14.86%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	65.33%
HIV Viral Load Suppression—Ages 18–64 Years	2.93%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	9.12%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.96%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.92
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	6.15%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	0.00%

Assessment of Corrective Action Plan—Acute and Chronic Disease Management Domain

In April 2020, to allow MCPs to focus efforts on the COVID-19 response, DHCS waived requirements for remaining IP and CAP submissions related to reporting year 2019 performance measure results. Following is a summary of the quality improvement activities that Partnership conducted as part of its CAP prior to April 2020.

DHCS approved Partnership to conduct PDSA cycles to address the MCP's performance below the minimum performance level for the *Asthma Medication Ratio—Total* measure in the Northeast, Northwest, and Southwest regions in reporting year 2019. Partnership conducted two PDSA cycles to test whether conducting provider in-person asthma medication ratio academic detailing sessions would result in providers prescribing more controller medications in relation to rescue medications when compared to the baseline measurement. Partnership indicated that the MCP was unable to discuss site-specific performance or detailed pharmacy fill reports during the academic detailing sessions. In response to this challenge, Partnership initiated contact with the provider partner to discuss site-specific reports and data.

DHCS did not hold MCPs accountable to meet the minimum performance level for any measure in reporting year 2020; therefore, HSAG makes no assessment of Partnership's performance related to the *Asthma Medication Ratio—Total* measure.

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, Partnership will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Note that in September 2020, DHCS notified Partnership that DHCS was closing the MCP's CAP, which was based on DHCS' previous performance measure set (External Accountability Set). To ensure continued monitoring of Partnership's performance, DHCS will require Partnership to meet quarterly via telephone with the MCP's assigned DHCS nurse consultant. While DHCS notified Partnership of the CAP closure outside the review period for the MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.17 through Table 3.20 present the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.17—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Partnership—Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties)

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	89.44	49.52	Not Tested	53.55

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	92.50%	Not Comparable	92.43%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	88.96%	83.32%	5.64	83.43%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	96.02%	82.28%	13.74	82.75%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	85.12%	81.62%	3.50	81.77%
*Plan All-Cause Readmissions—Total***	9.23%	6.30%	2.93	7.49%

Table 3.18—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Partnership—Northwest (Del Norte and Humboldt Counties)

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	79.46	38.26	Not Tested	41.58
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	94.38%	Not Comparable	94.40%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	88.70%	85.17%	3.53	85.25%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	89.44%	84.95%	4.49	85.09%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	91.76%	84.30%	7.46	84.60%
*Plan All-Cause Readmissions—Total***	9.23%	6.26%	2.97	7.26%

Table 3.19—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Partnership—Southeast (Napa, Solano, and Yolo Counties)

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	87.19	45.70	Not Tested	48.93
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	94.38%	Not Comparable	94.35%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	89.11%	86.65%	2.46	86.70%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	91.54%	87.72%	3.82	87.85%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	91.77%	87.22%	4.55	87.39%
*Plan All-Cause Readmissions—Total***	10.34%	6.65%	3.69	7.85%

Table 3.20—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations Partnership—Southwest (Lake, Marin, Mendocino, and Sonoma Counties)

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

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

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

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

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

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

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

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	84.90	44.50	Not Tested	47.04
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	95.33%	Not Comparable	95.31%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	94.02%	89.21%	4.81	89.28%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	94.90%	89.47%	5.43	89.60%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	93.63%	89.33%	4.30	89.45%
*Plan All-Cause Readmissions—Total***	11.63%	8.12%	3.51	9.12%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that Partnership stratified by the SPD and non-SPD populations and for which HSAG could compare the reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results:

- The reporting year 2020 SPD rates were significantly better than the reporting year 2020 non-SPD rates for the following measures:

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years* in the Southwest Region
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years* in the Northeast, Southeast, and Southwest regions
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years* in the Northwest, Southeast, and Southwest regions

♦ In all four regions, the SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

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

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

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

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

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

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

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

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, Partnership submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, Partnership initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

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

Table 4.1 provides the SMART Aim measure results reported by the MCP for its *Diabetes Nephropathy Screening* Disparity PIP.

Table 4.1—Partnership *Diabetes Nephropathy Screening* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of nephropathy screening among members diagnosed with diabetes, ages 18 to 75, assigned to Health Center A[6]	73.00%	88.32%	No

[6] Health center name removed for confidentiality.

Table 4.2 presents a description of the intervention that Partnership tested for its *Diabetes Nephropathy Screening* Disparity PIP. The table also indicates the failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—Partnership *Diabetes Nephropathy Screening* Disparity PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Implement a new workflow for medical assistants to be responsible for including nephropathy screening as part of the standing orders for members diagnosed with diabetes	♦ Providers do not create a lab order for nephropathy screening ♦ Medical assistants do not merge the order with the standing orders	Continue Testing

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Partnership's *Diabetes Nephropathy Screening* Disparity PIP. In the modules, Partnership documented that it originally planned to test two interventions; however, due to the complexity of the communication between the front and back office staff members regarding the need for and results of the urine samples, the MCP determined to cancel testing the efficiency of having the front office staff members request urine samples from members during registration. Instead, the MCP and the provider partner decided to continue to have the back office medical assistants request and obtain urine samples from members who were due for nephropathy screening.

Beginning in February 2019, Partnership began to test the impact of holding the medical assistants responsible for including nephropathy screening in the standing orders for members diagnosed with diabetes. The purpose of this intervention was to assign particular staff members the responsibility for creating the lab order to reduce the confusion regarding which staff members were responsible for ordering the diabetes nephropathy screening. Partnership indicated that while it did not achieve the SMART Aim goal, the tested intervention resulted in more members completing their nephropathy screening; therefore, the MCP determined to conduct further testing to determine the impact of the intervention on the overall SMART Aim measure.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned Partnership's *Diabetes Nephropathy Screening* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on Partnership's reporting year 2017 performance measure results, the MCP selected childhood immunizations as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure results as reported by the MCP for its *Childhood Immunization Status—Combination 3* PIP.

Table 4.3—Partnership *Childhood Immunization Status—Combination 3* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of *Childhood Immunization Status—Combination 3* measure among members residing in Lassen County	35.51%	52.17%	Yes

Table 4.4 presents a description of the intervention that Partnership tested for its *Childhood Immunization Status—Combination 3* PIP. The table also indicates the failure mode that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.4—Partnership *Childhood Immunization Status—Combination 3* PIP Intervention Testing Results

Intervention	Failure Mode Addressed	Adopt, Adapt, Abandon, or Continue Testing
Have provider partner review immunization records and outreach to parents/guardians of members who are approaching 2 years of age and who can complete their final *Childhood Immunization Status—Combination 3* vaccination series doses prior to their 2nd birthday to confirm their appointment or schedule an appointment to administer the final doses	Lack of effective population engagement to complete the vaccination series	Continue Testing

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for Partnership's *Childhood Immunization Status—Combination 3* PIP. In the modules, Partnership documented that it tested the impact of having the provider partner conduct outreach to the parents/guardians of members who were approaching 2 years of age to encourage them to fully complete their children's vaccination series. After testing the intervention through the first two PDSA cycles, the MCP decided to adapt the intervention to include distribution of a flyer to members to offer a $25 gift card incentive for completing the needed immunizations. Partnership determined that the intervention was successful in increasing the *Childhood Immunization Status—Combination 3* vaccination series completion and achieving the SMART Aim goal. The MCP indicated that it postponed continuing the intervention testing due to provider partner disengagement and noted that it plans to work with other provider partners to further test the effectiveness of the outreach intervention.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned Partnership's *Childhood Immunization Status—Combination 3* PIP a final confidence level of *Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, Partnership identified well-child visits in the first 15 months of life among Hispanic/Latino members as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits in the First 15 Months of Life* Health Equity PIP. Upon initial review of the modules, HSAG determined that Partnership met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the:
  - SMART Aim statement.
  - SMART Aim data collection methodology.
  - SMART Aim run chart.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Labeling clearly the identified gaps or opportunities for improvement in the process map steps.

- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.

After receiving technical assistance from HSAG, Partnership incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. Partnership was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, Partnership selected well-child visits for members ages 3 to 6 years as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 through 3 for the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. Upon initial review of the modules, HSAG determined that Partnership met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the:
  - SMART Aim statement.
  - SMART Aim data collection methodology.
  - SMART Aim run chart.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Linking logically the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.
- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.
- Ensuring that the intervention effectiveness measure was appropriate for the intervention.

After receiving technical assistance from HSAG, Partnership incorporated HSAG's feedback into modules 1 through 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 through 3.

Table 4.5 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP.

Table 4.5—Partnership *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of well-child visits among members 3 to 6 years of age assigned to Health Center B[7]	68.14%	74.00%

Table 4.6 presents a description of the intervention that Partnership selected to test for its *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. The table also indicates the failure modes that the intervention aims to address.

Table 4.6—Partnership *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP Intervention Testing

Intervention	Failure Modes Addressed
Coordinate Saturday clinics specifically for well-child appointments for the 3-to-6-year-old population	♦ Next available well-child appointments can be booked out for up to three months ♦ Parents are not available to bring their children to appointments during normal business hours

While Partnership advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Partnership achieved the SMART Aim goal for the 2017–19 *Childhood Immunization Status—Combination 3* PIP, and some of the quality improvement activities could be linked to the demonstrated improvement. Based on its assessment, HSAG assigned the 2017–19 *Childhood Immunization Status—Combination 3* PIP a final confidence level of *Confidence*.

Opportunities for Improvement—Performance Improvement Projects

Partnership has the opportunity to continue testing interventions and monitor outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 PIPs. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.

[7] Health center name removed for confidentiality.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

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

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

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the

statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

Partnership submitted the MCP's final PNA report to DHCS on July 9, 2020, and DHCS notified the MCP via email on July 10, 2020, that DHCS approved the report as submitted. While Partnership submitted the PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 7.1 provides EQR recommendations from Partnership's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of Partnership's self-reported actions.

Table 7.1—Partnership's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Institute monitoring of rejected claims for capitated services to ensure that complete data are received in time for performance measure reporting.	A reject encounter file will be transmitted to the delegate electronically on a 997 acknowledgement file and 277CA response file for correction and resubmission when submissions are of rejected encounters. The provider will have 14 days to resubmit the corrected encounter file or corrected encounter data within. Partnership will monitor all rejected submissions and may assess a CAP and/or withhold a percentage of capitation for the month following the non-submission until the complete encounter data file is received and accepted by Partnership. Encounter data and encounter data files will be completed in accordance with Partnership's Capitated Agreement and DHCS Quality Measures for Encounter Data, and penalties may apply.
2. Increase oversight of the data received from Kaiser to ensure that Kaiser has included all appropriate fields in the data files for performance measure data calculation and conduct ongoing data checks to ensure that corrective actions can be	Partnership continues to work closely with Kaiser's HEDIS encounter data team to ensure timely, accurate, and complete data are provided to Partnership both monthly and annually in support of annual HEDIS reporting. This has entailed building in contractual language to hold Kaiser accountable for data accuracy and routine monitoring of encounter and supplemental data via Partnership's comprehensive data quality monitoring dashboards. At its HEDIS 2020 on-site audit, Partnership presented its polished data monitoring activities and newly developed dashboards,

2018–19 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
instituted prior to sample selection for hybrid measures as well as rate calculation.	which support a greater level of transparency and monitoring to escalate issues for timely resolution.
3. Determine whether the MCP needs to modify or expand its current strategies to improve the MCP's performance to above the minimum performance levels for the following measures:	
♦ *Asthma Medication Ratio* in the Northeast, Northwest, and Southwest regions (The rates for this measure were also below the minimum performance level in reporting year 2018 for the Northeast and Northwest regions.)	Partnership engaged in a multi-pronged approach to address underperforming *Asthma Medication Ratio* measure rates in the Northeast, Northwest, and Southwest regions. Strategies included: ♦ Created an educational training curriculum to educate prescribers about the *Asthma Medication Ratio* measure specifications, updated Global Initiative on Asthma (GINA) guidelines, prescribing best practices, and formulary changes. These offerings are referred to as academic detailing sessions. They have been held with individual primary care provider (PCP) sites to tailor the delivery of the information and data to the location. Partnership is in the process of obtaining continuing medical education and continuing education credits to help encourage clinical participation. Thus far, feedback has been largely positive for the 18 *Asthma Medication Ratio* measure academic detailing sessions provided. Analysis is currently underway to assess the impact of recommended prescribing changes on measure performance or for sites that participated. ♦ For the mandated PDSA on the *Asthma Medication Ratio* measure, Partnership led *Asthma Medication Ratio* measure academic detailing sessions in the Southwest Region, completing two cycles with two federally qualified health centers prior to when the COVID-19 pandemic began. Reception was very positive. The data at the sub-region (Southwest) level suggest that the *Asthma Medication Ratio* measure academic detailing sessions have influenced prescribing practices. ♦ Partnership conducted targeted education on the *Asthma Medication Ratio* measure and sought collaboration with community pharmacies, resulting in seven in-person pharmacy visits. Partnership recognizes the unique

2018–19 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	opportunities pharmacists have to engage with and educate members on their prescription use when members are filling their asthma medications. Partnership also encouraged dialogue between the pharmacist and prescriber if the pharmacist observed potential misuse or overuse of rescue medications. ♦ Partnership is in the process of developing member-facing educational materials to share with members and providers that highlight proper asthma care and self-monitoring and control.
♦ *Breast Cancer Screening* in the Northwest Region (The rate for this measure was also below the minimum performance level in reporting year 2018 for this reporting unit.)	Partnership analyzed where members in the Northwest Region received their mammograms. It was identified that the majority were provided by a small number of imaging sites. This resulted in some imaging providers having impacted access, which resulted in delays in orders for mammograms. Another barrier observed was distance to imaging providers. In the rural areas in the Northwest Region, some members were required to drive over an hour to their closest imaging provider. Understanding these two barriers, Partnership elected to pilot a mobile mammography system with the largest provider in the Northwest Region, Open Door Community Health Centers, as part of its state-mandated PDSA cycle project. Partnership worked with a mobile mammography vendor to conduct several mammography clinics at provider sites in the region. Clinics were held on September 5, 2019, and January 9, 2020. With the onset of COVID-19, mobile mammography was paused in March 2020 and will recommence in late summer and early fall. For the two clinics participating in the PDSA cycles, the results were largely positive, looking at measure performance as well as member satisfaction. Use of a mobile vendor created guaranteed access and provided convenience to members by offering the service at their PCP site. Beyond the state-mandated PDSA cycles, several provider sites in the Northwest Region have independently used the mobile mammography vendor to host mammography clinics at their sites. Given the success of the pilot, Partnership is working with the vendor and provider sites to try and establish a regular route in the Northwest Region to ensure a level of consistency for mammogram access.

2018–19 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
♦ *Childhood Immunization Status—Combination 3* in the Northeast and Northwest regions (The rates for this measure have been below the minimum performance levels for more than three consecutive years in these reporting units.)	Partnership has implemented several strategies to combat low pediatric immunization rates in all four sub-regions. With the transition to the *Childhood Immunization Status—Combination 10* measure in 2019, new barriers were introduced that must be addressed. ♦ Partnership partnered with Open Door Community Health Centers to conduct a state-mandated PDSA cycle project. In the first cycle, the project aimed to target members who were at risk for not receiving flu doses, which was a new challenge based on the requirements of the *Childhood Immunization Status—Combination 10* measure. Upon analysis, Cycle 1 showed that there was a more immediate barrier present with rotavirus. Cycle 2 focused on members who were at risk of missing the rotavirus doses, which would result in members not meeting the measure requirements if not addressed. With the onset of COVID-19, the PDSA cycle requirements were waived by DHCS; however, the provider continued its focus on scheduling these pediatric patients as much as possible during the ongoing pandemic. ♦ Partnership has collaborated on and partially funded a media campaign in the Northeastern Region. The campaign is called Shasta Vax Facts and is being led by Shasta Community Health Center. The campaign will utilize social media, mailers, and printed materials. Multiple stakeholders in the community are contributing to the effort. This campaign will run for 90 days, during which data will be provided showing members targeted and/or engaged. This campaign was on track to be completed in the first half of 2020 but was paused at the onset of the statewide shelter-in-place orders for COVID-19. The exact timing for launching this campaign, potentially still in 2020, is yet to be determined. ♦ In the 2017–18 EQR response, Partnership cited its work to deliver supplemental immunization dose reports to support providers in tracking their assigned 0-to-2-year-old members' progress in completing timely immunizations. These reports include member-level dates of service by immunization dose per claims and California Immunization Registry data. Prior to the development of these reports, we learned that providers often had limited

2018–19 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	visibility and very little recourse to catch members up when members approach age 2 and become eligible under our pay-for-performance program. Providers shared it was difficult to reconcile immunization progress using their electronic health records and California Immunization Registry data. In 2019–20, Partnership was successful in integrating these reports within its pay-for-performance provider portal, eReports, in May 2020. This integration delivers on-demand provider access with monthly refreshing of the reports. Prior to this, the reports were provided ad hoc via secure email quarterly.
♦ *Immunizations for Adolescents—Combination 2* in the Northeast and Northwest regions (The rate for this measure was also below the minimum performance level in reporting year 2018 in the Northeast Region.)	Partnership is aware of several drivers that led to low rates for the *Immunizations for Adolescents—Combination 2* measure. Several activities aimed at addressing these drivers included: ♦ A state-mandated PDSA cycle project in collaboration with Open Door Community Health Centers. The intervention utilized member incentives to encourage members to receive all immunizations in the *Immunizations for Adolescents—Combination 2* measure series. This intervention had shown promise in previous PDSA cycle projects with other regional providers. In the second PDSA cycle, members were also targeted earlier, in the ages 9 to 12 years range, to give extra time for the spacing between human papillomavirus (HPV) doses. This was another barrier identified in previous PDSA cycle projects. A sizeable portion of the denominator only missed the measure because they did not complete the second HPV dose. ♦ Partnership has conducted several outreach campaigns to adolescent members, encouraging them to receive their immunizations. One campaign in fall 2019 and another in February 2020 focused on outreaching to members in multiple counties who had not completed their second HPV dose. This was a key lesson learned from previous improvement projects. Partnership has conducted five outreach campaigns as a result of requests from providers in Mendocino, Humboldt, Del Norte, and Trinity counties. Providers requested help reaching members to encourage them to seek immunizations since they had been unable to contact members with the information they had

<table>
<tr><th>2018–19 External Quality Review Recommendations Directed to Partnership</th><th>Self-Reported Actions Taken by Partnership during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations</th></tr>
<tr><td></td><td>available. Partnership also worked with Shasta County Health and Human Services (SCHHS) to conduct an outreach campaign in June 2019, requesting members receive required immunizations before going back to school. Another SCHHS campaign was initiated in mid-June 2020 and will be completed by early July 2020. The aim is to contact members and advise them to get immunizations earlier since COVID-19 requires social distancing and SCHHS will have less access as a result. Getting the message out sooner is key as SCHHS will not be able to accommodate a surge before students go back to school.
♦ Partnership has historically worked with middle schools in Shasta County to conduct immunization poster campaigns. The aim is to educate students on the importance of immunizations and offer an opportunity to create posters with a positive immunization message for a contest at their school’s open house. Students vote on their favorite immunization poster, which Partnership uses and posts in the community. Partnership had a 2019–20 cohort including five middle schools in Shasta County and at least one in Humboldt County, through spread and sharing with a community coalition in the Northwest Region. Plans were also in place for expanding to Siskiyou County. With the onset of COVID-19 and conversion of all schools to online instruction in spring 2020, the entire 2019–20 campaign was suspended. Partnership will be reevaluating if and how this campaign may reconvene over the 2020–21 school year.
The integration of on-demand access to supplemental immunization dose reports, cited previously in the response to the Childhood Immunization Status measure recommendations, also applies to the Immunizations for Adolescents—Combination 2 measure. These reports support providers in tracking their assigned 9-to-13-year-old members’ progress in completing timely immunizations.</td></tr>
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2018–19 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* in the Northeast and Northwest regions (The rate for this measure was also below the minimum performance level in reporting year 2018 in the Northwest Region.)	Partnership has utilized multiple levers to address lagging rates in the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. Examples include: ♦ A state-mandated PIP in partnership with Shasta Community Health Center. The provider and Partnership project manager have identified that access remains a barrier to members receiving well-child visits. After developing a key driver diagram and failure modes and effects analysis, the two parties determined conducting Saturday clinics dedicated to well-visits could offer the capacity to address the need for access. This intervention is slated to begin in late summer 2020; however, this could change based on COVID-19. ♦ Partnership has expanded use of its northern region pilot program, Birthday Club. This pilot offers a $25 gift card to members ages 3 to 6 who complete their well visits within their birthday month. The program started with three parent organizations participating, and these providers showed modest to significant gains in their *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates. Starting January 2020, the pilot was expanded to 11 parent organizations accounting for 36 sites. Most providers continued participating post-COVID-19 and welcomed Partnership's loosening of requirements to complete the visit within 60 days of the member's birthday to qualify for the reward. This pilot is planned to continue through 2020.

Assessment of MCP's Self-Reported Actions

HSAG reviewed Partnership's self-reported actions in Table 7.1 and determined that Partnership adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. Partnership described in detail actions taken during the review period to address the recommendations, results from the MCP's assessment of declining performance, and strategies the MCP is implementing to improve performance. HSAG identified the following notable actions taken by the MCP in response to the 2017–18 EQRO recommendations:

- Modified its processes to strengthen the MCP's monitoring of rejected claims for capitated services to ensure the MCP receives complete data in time for performance measure reporting.
- Improved its oversight processes of Kaiser (a plan partner) to ensure accountability by Kaiser for providing complete data for performance measure reporting.
- To address declining performance or performance below the minimum performance levels, implemented and planned multi-pronged strategies, including conducting provider trainings, developing partnerships with community organizations (e.g., pharmacies, mobile mammography vendor, clinics), creating member educational materials, offering member incentives, and conducting media campaigns.

2019–20 Recommendations

Based on the overall assessment of Partnership's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends that the MCP continue testing interventions and monitor outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 PIPs. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.

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

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix BB:
Performance Evaluation Report
Rady Children's Hospital—San Diego
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

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

This appendix is specific to DHCS' contracted PSP, Rady Children's Hospital—San Diego ("RCHSD" or "the PSP"). The purpose of this appendix is to provide PSP-specific results of each activity and an assessment of the PSP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this PSP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in RCHSD's 2020–21 PSP-specific evaluation report. This PSP-specific evaluation report references activities and methodologies described in detail in the technical report section.

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

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Population-Specific Health Plan Overview

RCHSD is a full-scope MCP delivering services to beneficiaries with specialized health care needs under the PSP model. RCHSD became operational in San Diego County to provide MCMC services effective July 1, 2018. As of June 2020, RCHSD had 370 members.[1]

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for RCHSD. HSAG's compliance review summaries are based on final audit/survey reports issued and corrective action plan (CAP) closeout letters dated on or before the end of the review period for this report (June 30, 2020).

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of RCHSD. A&I conducted the audits from September 9, 2019, through September 11, 2019. The audit review period included the PSP's first year of operation in MCMC and examined RCHSD's compliance with its DHCS contract.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of RCHSD
Audit Review Period: September 1, 2018, through August 31, 2019

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

Strengths—Compliance Reviews

In response to the CAP from the 2019 A&I Medical and State Supported Services Audits of RCHSD, the PSP provided documentation to DHCS that resulted in DHCS closing the CAP. RCHSD's documentation reflected changes to policies and procedures to ensure the PSP is compliant with DHCS' contract requirements.

Opportunities for Improvement—Compliance Reviews

RCHSD has no outstanding findings from the 2019 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the PSP in the area of compliance reviews.

3. Population-Specific Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by PSPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with PSPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by PSPs.

Hybrid Measure Reporting

PSPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to PSP and provider staff members related to COVID-19, DHCS allowed PSPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- ♦ Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- ♦ Report the measurement year 2018 audited hybrid rates, if available (i.e., the PSP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- ♦ Report the hybrid rates using measurement year 2019 administrative data only.

RCHSD chose to report all hybrid measures according to the reporting year 2020 measure specifications using measurement year 2019 data.

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

[2] The reporting year is the year in which PSPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

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

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

DHCS-Established Performance Levels

To assess performance for each PSP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for select MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold PSPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all PSPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold PSPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all PSPs:

- ♦ Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. PSPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow PSPs flexibility regarding the Plan-Do-Study-Act (PDSA) cycle format and interventions. PSPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- ♦ Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. PSPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the PSP contracts authorize DHCS to impose sanctions on PSPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding PSPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

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

Performance Measure Validation Results

HSAG conducted an independent audit of RCHSD, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Rady Children's Hospital—San Diego* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that RCHSD followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results

After validating the PSP's performance measure rates, HSAG assessed the results. See Table 3.1 for RCHSD's performance measure results for reporting year 2020.

Note the following regarding Table 3.1:

- The table presents reporting year 2020 rates only, since reporting year 2020 is the first year RCHSD reported performance measure rates. The EQRO will display performance measure rate comparisons in RCHSD's 2020–21 PSP-specific evaluation report and trending beginning in the 2021–22 PSP-specific evaluation report.
- Based on DHCS not holding PSPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the PSP's reporting year 2020 performance measure results.

Table 3.1—Reporting Year 2020 Performance Measure Results
RCHSD—San Diego County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

NA = The PSP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Measure	Reporting Year 2020 Rate
Children's Health Domain	
Adolescent Well-Care Visits	42.62%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	73.47%

Measure	Reporting Year 2020 Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	72.73%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	66.67%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	99.46%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.91%
Women's Health Domain	
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	NA
Contraceptive Care—All Women—LARC—Ages 21–44 Years	NA
Acute and Chronic Disease Management Domain	
*Ambulatory Care—ED Visits—Total**	73.86

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, RCHSD will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the PSP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Strengths—Performance Measures

The HSAG auditor determined that RCHSD followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Opportunities for Improvement—Performance Measures

Based on DHCS not holding PSPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability.

2019–21 Performance Improvement Projects

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, RCHSD initiated two 2019–21 PSP-specific PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the PSP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2019–21 Diabetes Performance Improvement Project

RCHSD selected diabetes as one of its 2019–21 PIP topics based on its PSP-specific data.

During the review period of this report, HSAG validated modules 1 through 3 for the PSP's *Diabetes* PIP. Upon initial review of the modules, HSAG determined that RCHSD met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of:
  - The SMART Aim.
  - The SMART Aim data collection methodology.
  - The SMART Aim run chart.
- Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Including all required components of the Intervention Plan.

- Ensuring that the intervention effectiveness measure was appropriate for the intervention.
- Ensuring that the data collection process was appropriate for the intervention effectiveness measure.

After receiving technical assistance from HSAG, RCHSD incorporated HSAG's feedback into modules 1 through 3. Upon final review, HSAG determined that the PSP met all validation criteria for modules 1 and 2. RCHSD was in the process of working on its Module 3 resubmission when DHCS determined to end the 2019–21 PIPs.

2019–21 Flu Vaccination Performance Improvement Project

RCHSD selected flu vaccinations for children and adolescents as its second 2019–21 PIP topic based on its PSP-specific data.

During the review period for this report, HSAG validated modules 1 through 3 for the PSP's *Flu Vaccination* PIP. Upon initial review of the modules, HSAG determined that RCHSD met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of:
  - The SMART Aim.
  - The SMART Aim data collection methodology.
  - The SMART Aim run chart.
- Confirming that the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Including all required components of the Intervention Plan.
- Ensuring that the intervention effectiveness measure was appropriate for the intervention.
- Ensuring that the data collection process was appropriate for the intervention effectiveness measure.

After receiving technical assistance from HSAG, RCHSD incorporated HSAG's feedback into modules 1 through 3. Upon final review, HSAG determined that the PSP met all validation criteria for modules 1 and 2. RCHSD was in the process of working on its Module 3 resubmission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, RCHSD submitted all PIP documentation as required.

Opportunities for Improvement—Performance Improvement Projects

Based on RCHSD's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the seniors and persons with disabilities population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

RCHSD submitted the PSP's PNA report to DHCS on June 1, 2020, and DHCS notified the PSP via email on June 23, 2020, that DHCS approved the report as submitted.

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 6.1 provides EQR recommendations from RCHSD's July 1, 2018, through June 30, 2019, PSP-specific evaluation report, along with the PSP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 6.1 to preserve the accuracy of RCHSD's self-reported actions.

Table 6.1—RCHSD's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, PSP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to RCHSD	Self-Reported Actions Taken by RCHSD during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS and HSAG to ensure that the PSP fully understands all EQRO activities and DHCS' requirements of the PSP related to each activity.	To understand the EQRO activities and requirements, RCHSD participated in direct communication with DHCS and HSAG, including calls and meetings. RCHSD attended the following HSAG-hosted webinars: ♦ Pre-Medical Record Review Validation Webinar for Organizations (California) ♦ Review of HSAG Supplemental Data Validation Process with All Health Plans—California ♦ Annual HEDIS Updates Webinar for California Health Plans. Additionally, RCHSD successfully completed all DHCS Medi-Cal performance measure audit activities as outlined by HSAG.

Assessment of PSP's Self-Reported Actions

HSAG reviewed RCHSD's self-reported actions in Table 6.1 and determined that RCHSD adequately addressed HSAG's recommendation from the PSP's July 1, 2018, through June 30, 2019, PSP-specific evaluation report. RCHSD noted that the PSP participated in direct communication with both DHCS and HSAG to ensure understanding of the EQRO activities

and requirements and summarized the trainings in which the PSP participated related to performance measure reporting.

2019–20 Recommendations

Based on the overall assessment of RCHSD's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the PSP.

In the next annual review, the EQRO will evaluate continued successes of RCHSD.

Medi-Cal Managed Care External Quality Review Technical Report

Appendix CC: Performance Evaluation Report San Francisco Health Plan

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the PIHP with a specialized population as an SHP. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, San Francisco Health Plan ("SFHP" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in SFHP's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

SFHP is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in SFHP, the Local Initiative MCP, or in Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, the alternative commercial plan.

SFHP became operational in San Francisco County to provide MCMC services effective January 1997. As of June 2020, SFHP had 129,167 members in San Francisco County.[1] This represents 88 percent of the beneficiaries enrolled in San Francisco County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for SFHP.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of SFHP. A&I conducted the audits from March 2, 2020, through March 12, 2020. The audits examined documentation for compliance and determined to what extent SFHP had implemented its corrective action plan (CAP) from the prior audits. DHCS issued the final audit reports on July 17, 2020, which is outside the review period for this report; however, HSAG includes the information from the reports because A&I conducted the on-site audits during the review period for this report.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of SFHP
Audit Review Period: March 1, 2019, through February 29, 2020

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	Yes	CAP in process and under review.
Member's Rights	Yes	CAP in process and under review.
Quality Management	Yes	CAP in process and under review.
Administrative and Organizational Capacity	Yes	CAP in process and under review.
State Supported Services	Yes	CAP in process and under review.

Follow-Up on 2018 and 2019 Medical and State Supported Services Audits

A&I conducted on-site Medical and State Supported Services Audits for SFHP from March 5, 2018, through March 16, 2018, and February 25, 2019, through March 1, 2019, covering the review periods of March 1, 2017, through February 28, 2018, and March 1, 2018, through February 28, 2019, respectively.

At the time of the 2018–19 MCP-specific evaluation report publication, SFHP's CAP was in progress and under review by DHCS. At the time of this 2019–20 MCP-specific evaluation report publication, SFHP's CAP from the 2018 and 2019 audits is still in process. HSAG will provide an update on the status of this CAP in SFHP's 2020–21 MCP-specific evaluation report.

Strengths—Compliance Reviews

SFHP provided a summary of the dates on which the MCP submitted documentation to DHCS to address all findings from the 2018 and 2019 Medical and State Supported Services Audits (see Table 7.1). SFHP noted that it will continue to work with DHCS to ensure all findings are fully resolved so that the CAP can be closed.

Opportunities for Improvement—Compliance Reviews

SFHP has the opportunity to continue to work with DHCS to ensure the MCP submits all documentation necessary for DHCS to close the CAP from the 2018 and 2019 Medical and State Supported Services Audits. Additionally, SFHP has the opportunity to address findings from the 2020 Medical and State Supported Services Audits by implementing the actions recommended by A&I.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures SFHP chose to report using one or both of these two options.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

[3] HEDIS® is a registered trademark of NCQA.

[4] HEDIS Compliance Audit™ is a trademark of NCQA.

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

[5] Quality Compass® is a registered trademark of NCQA.

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of SFHP, and the *HEDIS 2020 Compliance Audit Final Report of Findings for San Francisco Health Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that SFHP followed the appropriate specifications to produce valid rates; however, during preliminary rate review, the auditor determined that the MCP excluded Medi-Cal members whose primary insurance coverage was Medicare, regardless of the time period of their dual eligible coverage. The auditor indicated that SFHP should implement corrections to ensure enrollment span determinations occur monthly so that dual eligible members remain in Medi-Cal reporting during those months in which their primary insurance coverage is not through Medicare or commercial insurers.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for SFHP's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
SFHP—San Francisco County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	60.34%
Childhood Immunization Status—Combination 10	61.11%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	92.05%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	84.60%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	88.90%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	87.41%

Measure	Reporting Year 2020 Rate
Developmental Screening in the First Three Years of Life—Total	22.00%
Immunizations for Adolescents—Combination 2	61.60%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation—Total	83.57%
Well-Child Visits in the First 15 Months of Life— Six or More Well-Child Visits	69.34%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	82.80%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
SFHP—San Francisco County

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	65.89%
Cervical Cancer Screening	68.10%
Chlamydia Screening in Women—Ages 16–20 Years	55.56%
Chlamydia Screening in Women—Ages 21–24 Years	60.74%
Chlamydia Screening in Women—Total	58.06%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	13.78%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	20.25%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.77%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	4.47%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	5.55%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	32.69%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	27.38%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	S
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	23.08%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	10.98%
Prenatal and Postpartum Care—Postpartum Care	82.24%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.19%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
SFHP—San Francisco County

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	66.32%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	45.85%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	43.48%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.49%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.93%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	S

Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
SFHP—San Francisco County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	96.60%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	40.14

Measure	Reporting Year 2020 Rate
Asthma Medication Ratio—Total	72.79%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	27.11%
Comprehensive Diabetes Care—HbA1c Testing—Total	91.58%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	11.96%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	S
Controlling High Blood Pressure—Total	72.81%
HIV Viral Load Suppression—Ages 18–64 Years	13.69%
HIV Viral Load Suppression—Ages 65+ Years	S
*Plan All-Cause Readmissions—Observed Readmissions—Total***	10.57%
Plan All-Cause Readmissions—Expected Readmissions—Total	10.14%
*Plan All-Cause Readmissions—O/E Ratio—Total***	1.04
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	5.17%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	S

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, SFHP will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations SFHP—San Francisco County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

Performance comparisons are based on the Chi-square test of statistical significance, with a p value of <0.05.

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	89.13	34.60	Not Tested	40.14

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	NA	92.03%	Not Comparable	92.05%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	80.00%	84.65%	-4.65	84.60%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	85.80%	88.97%	-3.17	88.90%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	78.43%	87.65%	-9.22	87.41%
*Plan All-Cause Readmissions— Total***	13.24%	8.56%	4.68	10.57%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that SFHP stratified by the SPD and non-SPD populations and for which HSAG could make a comparison between the reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results in reporting year 2020:

- Members ages 12 to 19 years in the SPD population had significantly fewer visits with a primary care provider (PCP) during the measurement year than members in this age group in the non-SPD population. The significant differences may be attributed to members in this age group in the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from PCPs.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that SFHP followed the appropriate specifications to produce valid rates.

Opportunities for Improvement—Performance Measures

SFHP has the opportunity to update its enrollment determinations to monthly spans to ensure that dual eligible members remain in Medi-Cal reporting during those months in which their primary insurance coverage is not through Medicare or commercial insurers. Additionally, the MCP should assess which fields and values are used for coordination of benefits configurations to confirm that only valid, full medical coverage through a primary payer counts as an excluded enrollment segment.

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability.

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCP, PSP, or SHP accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCP, PSP, or SHP accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, SFHP submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, SFHP initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCPs experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, SFHP identified postpartum care among African-American members as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure results reported by the MCP for its *Postpartum Care* Disparity PIP.

Table 4.1—SFHP *Postpartum Care* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of postpartum visits that occur with an obstetrician/gynecologist (OB/GYN) or PCP within three to eight weeks of delivery among African-American members who deliver at Hospital A[6]	62%	91%	No

[6] Hospital name removed for confidentiality.

Table 4.2 presents a description of the intervention that SFHP tested for its *Postpartum Care* Disparity PIP. The table also indicates the failure modes that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—SFHP *Postpartum Care* Disparity PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Test the effectiveness of a new automated registry report to identify members who recently delivered babies to schedule postpartum care visits within three to eight weeks of delivery using appointment scheduling protocols	♦ Postpartum visits are not automatically scheduled upon discharge ♦ Postpartum visits are scheduled outside of the compliance window	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for SFHP's *Postpartum Care* Disparity PIP. SFHP documented in the modules that it tested the effectiveness of an automated registry report to identify members who recently delivered to conduct outreach with these members to schedule their postpartum care visits within the compliance time frame. The MCP tested the intervention from March 2019 through June 2019. Although SFHP outreached to a small number of members during the intervention testing phase, all outreached members scheduled their postpartum visit within the three to eight week time frame and the majority of the members attended their postpartum visit. Due to the success of the tested intervention, SFHP decided to adapt the intervention by increasing the denominator size to include a larger number of members. The MCP determined that increasing the denominator size would help to better assess the effectiveness of the intervention. Despite SFHP's efforts, the MCP did not achieve the SMART Aim goal.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned SFHP's *Postpartum Care* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Due to SFHP demonstrating high performance within DHCS' Quality Strategy focus areas, DHCS allowed the MCP to choose for its DHCS-priority PIP an alternative topic related to an

identified area in need of improvement. Based on its MCP-specific data, SFHP selected immunizations among adolescent members as its 2017–19 DHCS-priority PIP topic.

Table 4.3 provides the SMART Aim measure results as reported by the MCP for its *Immunizations for Adolescents—Combination 2* PIP.

Table 4.3—SFHP *Immunizations for Adolescents—Combination 2* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of human papillomavirus (HPV) vaccinations among adolescent members who turn 13 years of age	55.2%	59.3%	Yes

Table 4.4 presents a description of the intervention that SFHP tested for its *Immunizations for Adolescents—Combination 2* PIP. The table also indicates the key driver that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.4—SFHP *Immunizations for Adolescents—Combination 2* PIP Intervention Testing Results

Intervention	Key Driver Addressed	Adopt, Adapt, Abandon, or Continue Testing
Offer incentives to clinic staff members to use the immunization registry to identify and outreach to members who have received their first HPV vaccination and are due for their second dose	Need for the second dose of the HPV vaccine	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for SFHP's *Immunizations for Adolescents—Combination 2* PIP. While SFHP submitted plans to test two interventions, the MCP completed testing only one of the interventions. The MCP initially planned to provide training to select providers with low HPV vaccine completion rates on how to address challenges and/or concerns among adolescents and parents around HPV, HPV-related issues tailored to the patient population, and strategies for working with parents; however, SFHP determined that providers did not lack knowledge or advocacy related to the

vaccine and decided not to test the intervention. SFHP instead tested the impact of offering incentives to clinic staff members for using the immunization registry to identify members for outreach to schedule appointments for their second HPV vaccination dose. Although SFHP tested the intervention from December 2018 to June 2019, the MCP only obtained intervention effectiveness data from April 2019 to June 2019 because no systemic process for data tracking existed prior to April 2019. SFHP achieved the SMART Aim goal from April 2019 through June 2019; however, the MCP identified administrative burden as a barrier for the clinic staff members to continue this intervention and determined to adapt the intervention using more automated processes.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned SFHP's *Immunizations for Adolescents—Combination 2* PIP a final confidence level of *Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, SFHP identified breast cancer screening among African-American members as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 through 3 for the MCP's *Breast Cancer Screening* Health Equity PIP. Upon initial review of the modules, HSAG determined that SFHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology and SMART Aim run chart.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Ensuring that the intervention effectiveness measure was appropriate for the intervention.
- Ensuring that the data collection process was appropriate for the intervention effectiveness measure.

After receiving technical assistance from HSAG, SFHP incorporated HSAG's feedback into modules 1 through 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 through 3.

Table 4.5 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the MCP's *Breast Cancer Screening* Health Equity PIP.

Table 4.5—SFHP *Breast Cancer Screening* Health Equity PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of breast cancer screenings among African-American members	44.8%	58.7%

Table 4.6 presents a description of the intervention that SFHP selected to test for its *Breast Cancer Screening* Health Equity PIP. The table also indicates the failure mode that the intervention aims to address.

Table 4.6—SFHP *Breast Cancer Screening* Health Equity PIP Intervention Testing

Intervention	Failure Mode Addressed
Implement SFHP-sponsored mammovan events at Health Network A[7] clinics	♦ Members must travel to receive breast cancer screening, often in a different location than where their PCPs are located

While SFHP advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, SFHP selected well-child visits in the first 15 months of life as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 through 3 for the MCP's *Well-Child Visits in the First 15 Months of Life* PIP. Upon initial review of the modules, HSAG determined that SFHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of the SMART Aim data collection methodology.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.

[7] Health network name removed for confidentiality.

- Labeling clearly the identified gaps or opportunities for improvement in the process map steps.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.
- Including all required components of the Intervention Plan.
- Ensuring that the intervention effectiveness measure was appropriate for the intervention.
- Ensuring that the data collection process was appropriate for the intervention effectiveness measure.

After receiving technical assistance from HSAG, SFHP incorporated HSAG's feedback into modules 1 through 3. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 through 3.

Table 4.7 provides the SMART Aim measure description, baseline rate, and SMART Aim goal rate for the *Well-Child Visits in the First 15 Months of Life* PIP.

Table 4.7—SFHP *Well-Child Visits in the First 15 Months of Life* PIP SMART Aim Measure

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate
Rate of completion of at least six well-child visits among members by 15 months of age	12.8%	16.4%

Table 4.8 presents a description of the intervention that SFHP selected to test for its *Well-Child Visits in the First 15 Months of Life* PIP. The table also indicates the key drivers and failure modes that the intervention aims to address.

Table 4.8—SFHP *Well-Child Visits in the First 15 Months of Life* PIP Intervention Testing

Intervention	Key Drivers and Failure Modes Addressed
Conduct targeted outreach to members who are due for a well-child visit, including offering a financial incentive to members who attend the recommended number of well-child visits and sharing the importance of up-to-date preventive care services for children	♦ Parents/guardians are not provided with information about how and why six well-child visits need to occur in a timely manner ♦ Easy access to health promotion and health education materials for families ♦ Families trust and see value in health, developmental, and educational services

While SFHP advanced to the intervention testing phase, the PIP did not progress to the point where the MCP was required to report PIP outcomes prior to DHCS determining to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

SFHP achieved the SMART Aim goal for the 2017–19 *Immunizations for Adolescents—Combination 2* PIP, and some of the quality improvement activities could be linked to the demonstrated improvement. Based on its assessment, HSAG assigned the 2017–19 *Immunizations for Adolescents—Combination 2* PIP a final confidence level of *Confidence*.

Additionally, upon completion of the 2017–19 *Postpartum Care* Disparity PIP, SFHP identified an intervention that it can adapt to improve timely postpartum care visits among African-American members.

Opportunities for Improvement—Performance Improvement Projects

SFHP has the opportunity to continue monitoring adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 PIPs. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.

5. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 5.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 5.1.

Table 5.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

6. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

As part of NCQA's accreditation requirements, SFHP submits accreditation reports to NCQA that contain information similar to what DHCS requires for the PNA report; therefore, DHCS approved SFHP to submit sections of the MCP's NCQA accreditation reports to meet the PNA report requirements. SFHP submitted the MCP's PNA report to DHCS on June 30, 2020, and DHCS notified the MCP via email on July 29, 2020, that DHCS approved the report as submitted. While DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

7. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 7.1 provides EQR recommendations from SFHP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 7.1 to preserve the accuracy of SFHP's self-reported actions.

Table 7.1—SFHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP fully resolves all findings from the March 5, 2018, through March 16, 2018, and February 25, 2019, through March 1, 2019, Medical and State Supported Services Audits.	SFHP developed a CAP and has worked with the Managed Care Quality and Monitoring Division (MCQMD) to provide evidence of correction and close all but one of the open findings from both the 2018 and 2019 Medical and State Supported Services Audits. The open audit finding is unresolved from the 2018 and 2019 audit and was also a finding in the 2020 audit. SFHP is working closely with MCQMD to find a solution for this deficiency that can be implemented by the MCP. The CAP for the 2018 audit was submitted to DHCS on October 26, 2018. Additional documentation was submitted on January 16, 2019, February 11, 2019, February 27, 2019, March 12, 2019, and May 28, 2019. The 2019 Medical and State Supported Services Audits were conducted at SFHP from February 25, 2019, through March 1, 2019. The CAP for the 2019 audits was submitted on

2018–19 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
	August 12, 2019. Additional documentation was submitted on December 19, 2019, January 14, 2020, February 20, 2020, February 26, 2020, April 24, 2020, and July 10, 2020. SFHP is working closely with MCQMD to remediate all findings and will continue to work with MCQMD to close the remaining open finding.

Assessment of MCP's Self-Reported Actions

HSAG reviewed SFHP's self-reported actions in Table 7.1 and determined that SFHP adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. SFHP documented the various dates on which the MCP submitted documentation to DHCS to resolve findings from the 2018 and 2019 Medical and State Supported Services Audits. The MCP noted that only one audit finding in the Utilization Management category is unresolved from the 2018 and 2019 audits and that A&I identified the same finding in the 2020 audit. SFHP indicated that it continues to work closely with DHCS to identify a solution for this deficiency that the MCP can implement. Based on SFHP's self-reported actions, it appears the MCP is taking all needed steps to resolve all audit findings to ensure the MCP is fully compliant with DHCS' contract requirements.

2019–20 Recommendations

Based on the overall assessment of SFHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Continue to work with DHCS to ensure the MCP submits all documentation necessary for DHCS to close the CAP from the 2018 and 2019 Medical and State Supported Services Audits.
- Address findings from the 2020 Medical and State Supported Services Audits by implementing the actions recommended by A&I.
- Update its enrollment determinations to monthly spans to ensure that dual eligible members remain in Medi-Cal reporting during those months in which their primary insurance coverage is not through Medicare or commercial insurers. Additionally, the MCP

should assess which fields and values are used for coordination of benefits configurations to confirm that only valid, full medical coverage through a primary payer counts as an excluded enrollment segment.

- Continue monitoring adapted interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the 2017–19 PIPs. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the MCP to continually refine interventions to achieve and sustain optimal outcomes.

In the next annual review, the EQRO will evaluate continued successes of SFHP as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix DD:
Performance Evaluation Report
Santa Clara Family Health Plan
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the PIHP with a specialized population as an SHP. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, Santa Clara Family Health Plan ("SCFHP" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in SCFHP's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

SCFHP is a full-scope MCP delivering services to its members as a "Local Initiative" MCP under the Two-Plan Model. Beneficiaries may enroll in SCFHP, the Local Initiative MCP, or in Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan, the alternative commercial plan.

SCFHP became operational in Santa Clara County to provide MCMC services effective February 1997. As of June 2020, SCFHP had 245,135 members.[1] This represents 79 percent of the beneficiaries enrolled in Santa Clara County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for SCFHP.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical and State Supported Services Audits of SCFHP. A&I conducted the audits from March 9, 2020, through March 20, 2020. The Medical Audit portion was a reduced scope audit, evaluating five categories rather than six. A&I evaluated SCFHP's compliance with its DHCS contract and documentation in response to the 2019 Medical Audit's corrective action plan (CAP). DHCS issued the final reports on August 18, 2020, which is outside the review period for this report; however, HSAG includes the information from the reports because A&I conducted the on-site audits during the review period for this report. Note that the CAP from the 2019 Medical Audit is still open.

Table 2.1—DHCS A&I Medical and State Supported Services Audits of SCFHP
Audit Review Period: March 1, 2019, through February 29, 2020

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	Yes	CAP in process and under review.
Case Management and Coordination of Care	Yes	CAP in process and under review.
Access and Availability of Care	No	No findings.
Member's Rights	No	No findings.
Quality Management	No	No findings.
State Supported Services	No	No findings.

Strengths—Compliance Reviews

A&I identified no findings in the Access and Availability of Care, Member's Rights, Quality Management, and State Supported Services categories during the 2020 Medical and State Supported Services Audits of SCFHP.

Opportunities for Improvement—Compliance Reviews

SCFHP has the opportunity to work with DHCS to fully resolve the findings from the 2019 and 2020 Medical Audits. During the 2020 audit, A&I identified a repeat finding in the Case Management and Coordination of Care category related to the MCP needing to implement procedures to ensure timely completion of a comprehensive initial health assessment.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures SCFHP chose to report using one or both of these two options.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

[3] HEDIS® is a registered trademark of NCQA.

[4] HEDIS Compliance Audit™ is a trademark of NCQA.

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

[5] Quality Compass® is a registered trademark of NCQA.

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of SCFHP, and the *HEDIS 2020 Compliance Audit Final Report of Findings for Santa Clara Family Health Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that SCFHP followed the appropriate specifications to produce valid rates; however, during primary source verification of a sample of randomly selected dual eligible members, the auditor noted that all eight members demonstrated at least one month of dual eligible coverage during the measurement year in the MCP's enrollment system. The auditor indicated that to comply with NCQA's General Guideline 15 wherein exclusions are to be applied according to the continuous enrollment requirements for each measure, SCFHP should implement dual eligibility calculations in monthly enrollment spans.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for SCFHP's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
SCFHP—Santa Clara County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	51.82%
Childhood Immunization Status—Combination 10	66.91%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	94.54%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	88.69%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	90.82%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	88.49%

Measure	Reporting Year 2020 Rate
Developmental Screening in the First Three Years of Life—Total	20.51%
Immunizations for Adolescents—Combination 2	46.72%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	89.29%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	75.43%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.13%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
SCFHP—Santa Clara County

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	66.72%
Cervical Cancer Screening	61.07%
Chlamydia Screening in Women—Ages 16–20 Years	53.41%
Chlamydia Screening in Women—Ages 21–24 Years	66.12%
Chlamydia Screening in Women—Total	59.19%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	13.91%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	24.39%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	2.47%
Contraceptive Care—All Women—LARC—Ages 21–44 Years	5.47%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	19.10%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	19.42%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	50.56%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	42.09%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	14.61%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	9.65%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	33.15%
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	19.18%
Prenatal and Postpartum Care—Postpartum Care	85.16%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.19%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
SCFHP—Santa Clara County

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	63.57%
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	49.87%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	39.84%

Measure	Reporting Year 2020 Rate
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	46.03%
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	0.21%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	1.51%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	0.17%

Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
SCFHP—Santa Clara County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	92.46%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	38.84
Asthma Medication Ratio—Total	62.31%
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	31.14%
Comprehensive Diabetes Care—HbA1c Testing—Total	86.13%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	13.15%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	8.08%
Controlling High Blood Pressure—Total	62.04%

Measure	Reporting Year 2020 Rate
HIV Viral Load Suppression—Ages 18–64 Years	3.58%
HIV Viral Load Suppression—Ages 65+ Years	0.00%
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.30%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.09%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.91
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	0.00%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	0.00%

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, SCFHP will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations SCFHP—Santa Clara County

(green) = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

(red) = Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	47.71	37.64	Not Tested	38.84
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	NA	94.60%	Not Comparable	94.54%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	85.75%	88.74%	-2.99	88.69%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	81.75%	91.12%	-9.37	90.82%

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	81.91%	88.72%	-6.81	88.49%
*Plan All-Cause Readmissions—Total***	11.27%	7.17%	4.10	8.30%

Seniors and Persons with Disabilities—Performance Measure Findings

For measures that SCFHP stratified by the SPD and non-SPD populations and for which HSAG could compare the reporting year 2020 SPD rates and reporting year 2020 non-SPD rates, HSAG observed the following notable results:

- Members ages 7 to 11 years and 12 to 19 years in the SPD population had significantly fewer instances of a visit with a primary care provider (PCP) during the measurement year than members in these age groups in the non-SPD population in reporting year 2020. The significant differences may be attributed to members ages 7 to 19 in the SPD population choosing to receive all health care services from specialist providers due to their complicated health care needs, rather than accessing care from PCPs.
- The SPD population had a significantly higher hospital readmissions rate than the non-SPD population in reporting year 2020. Note that the higher rate of hospital readmissions for the SPD population is expected based on the greater and often more complicated health care needs of these members.

Strengths—Performance Measures

The HSAG auditor determined that SCFHP followed the appropriate specifications to produce valid rates.

Opportunities for Improvement—Performance Measures

SCFHP has the opportunity to update its process to implement calculations that verify dual eligibility in monthly enrollment spans and to ensure that dual eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to SCFHP's participation in California's Coordinated Care Initiative as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that SCFHP report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

Managed Long-Term Services and Supports Plan Performance Measure Results

Table 4.1 presents the reporting year 2020 rates for each required MLTSSP performance measure. Table 4.1 presents reporting year 2020 rates only, based on changes in performance measures and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 4.1—Reporting Year 2020 MLTSSP Performance Measure Results SCFHP—Santa Clara County

* Member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

Measure	Reporting Year 2020 Rate
*Ambulatory Care—ED Visits per 1,000 Member Months**	52.15
*Plan All-Cause Readmissions—Observed Readmissions—Total***	8.94%
Plan All-Cause Readmissions—Expected Readmissions—Total	9.72%
*Plan All-Cause Readmissions—O/E Ratio—Total***	0.92

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability.

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCP, PSP, or SHP accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCP, PSP, or SHP accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible (referred to in this report as "not credible")—the PIP methodology was not executed as approved.

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, SCFHP submitted final modules for its 2017–19 Disparity and DHCS-priority PIPs. HSAG provided final validation findings and encouraged the MCP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, SCFHP initiated the 2019–21 Health Equity and Child and Adolescent Health PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required MCPs to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own MCP-specific data, SCFHP identified immunizations among Vietnamese children as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 5.1 provides the SMART Aim measure results reported by the MCP for its *Childhood Immunization Status—Combination 3* Disparity PIP.

Table 5.1—SCFHP *Childhood Immunization Status—Combination 3* Disparity PIP SMART Aim Measure Results

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Childhood Immunization Status—Combination 3 measure rate among Vietnamese beneficiaries assigned to Provider Network C[6]	S	25.0%	No

[6] Provider network name removed for confidentiality.

Table 5.2 presents a description of the intervention that SCFHP tested for its *Childhood Immunization Status—Combination 3* Disparity PIP. The table also indicates the failure mode that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.2—SCFHP *Childhood Immunization Status—Combination 3* Disparity PIP Intervention Testing Results

Intervention	Failure Mode Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide incentives to members for obtaining immunizations according to the immunization schedule	Members' parents/guardians do not prioritize scheduling appointments to complete immunizations according to the immunization schedule	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for SCFHP's *Childhood Immunization Status—Combination 3* Disparity PIP. In the modules, SCFHP documented that it tested the effectiveness of a member incentive intervention to improve the immunization rate. The MCP conducted mail outreach to the parents/guardians of targeted members and offered a $30 gift card for their child's completion of the *Childhood Immunization Status—Combination 3* vaccination series. Based on intervention testing outcomes, the MCP determined that the incentive did not improve immunization series completion, and SCFHP did not achieve the SMART Aim goal. SCFHP determined it needed to consider alternative methods for outreach to reach more members' parents/guardians. Additionally, the MCP concluded that offering a gift card valued at only $30 may not have been adequate to motivate parents/guardians to take their child to multiple immunization appointments. SCFHP indicated adapting the intervention to test additional outreach methods and an increased gift card amount.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned SCFHP's *Childhood Immunization Status—Combination 3* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 DHCS-Priority Performance Improvement Project

DHCS required MCPs to conduct a PIP related to one of DHCS' Quality Strategy focus areas: *Childhood Immunization Status—Combination 3*, *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, or *Prenatal and Postpartum Care—Postpartum Care*. Based on SCFHP's reporting year 2017 performance measure results, the MCP selected controlling high blood pressure as its 2017–19 DHCS-priority PIP topic.

Table 5.3 provides the SMART Aim measure results as reported by the MCP for its *Controlling High Blood Pressure* PIP.

Table 5.3—SCFHP *Controlling High Blood Pressure* PIP SMART Aim Measure Results

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of adequately controlled blood pressure during the previous rolling 12-month period among beneficiaries ages 18 to 85, diagnosed with hypertension and assigned to Clinic A[7]	S	50.00%	No

Table 5.4 presents a description of the intervention that SCFHP tested for its *Controlling High Blood Pressure* PIP. The table also indicates the failure mode that the intervention addressed and whether the MCP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 5.4—SCFHP *Controlling High Blood Pressure* PIP Intervention Testing Results

Intervention	Failure Mode Addressed	Adopt, Adapt, Abandon, or Continue Testing
Provide incentives to members for controlling blood pressure	Members are aware of appointments to measure blood pressure but do not attend them	Abandon

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for SCFHP's *Controlling High Blood Pressure* PIP. In the modules, SCFHP documented that it tested the effectiveness of a member incentive intervention to improve blood pressure control among its members. The MCP mailed a letter to eligible members to offer a $25 gift card for completing a blood pressure check exam. SCFHP determined that the response rate to the incentive offer was very low throughout the testing period, and the MCP decided to abandon the intervention. The MCP did not achieve the SMART Aim goal.

[7] Clinic name removed for confidentiality.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned SCFHP's *Controlling High Blood Pressure* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required MCPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged MCPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged MCPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own MCP-specific data, SCFHP identified adolescent well-care visits in Network 20 as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's *Adolescent Well-Care Visits* Health Equity PIP. Upon initial review of the modules, HSAG determined that SCFHP met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- ♦ Including all required components of the SMART Aim data collection methodology.
- ♦ Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- ♦ Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- ♦ Linking logically the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.
- ♦ Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.
- ♦ Ensuring that the drivers and interventions in the key driver diagram are clearly stated, logically linked to the SMART Aim, and have the potential for impacting the SMART Aim goal.

After receiving technical assistance from HSAG, SCFHP incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. SCFHP was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, SCFHP selected well-child visits in the first 15 months of life as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits in the First 15 Months of Life* PIP. Upon initial review of the modules, HSAG determined that SCFHP met some required validation criteria; however, HSAG identified opportunities for improvement related to including:

- All required components of the:
  - SMART Aim statement.
  - SMART Aim data collection methodology.
  - SMART Aim run chart.
- A process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.

After receiving technical assistance from HSAG, SCFHP incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the MCP met all validation criteria for modules 1 and 2. SCFHP was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, SCFHP identified an intervention that it can adapt to improve childhood immunization series completion among members by their second birthday.

Opportunities for Improvement—Performance Improvement Projects

SCFHP has the opportunity to monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 3* Disparity PIP. Additionally, SCFHP has the opportunity to apply the lessons learned from both 2017–19 PIPs to facilitate improvement for future PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

SCFHP submitted the MCP's final PNA report to DHCS on August 11, 2020, and DHCS notified the MCP via email on August 12, 2020, that DHCS approved the report as submitted. While SCFHP submitted the final PNA report and DHCS sent the email outside the review period for this MCP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from SCFHP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of SCFHP's self-reported actions.

Table 8.1—SCFHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period of July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCP fully resolves all findings from the 2019 A&I Medical and State Supported Services audits.	The MCP is working diligently with DHCS in hopes of resolving the findings from the DHCS 2019 A&I Medical and State Supported Services Audits by the end of Q4 2020.
2. Identify the causes for the MCP's performance declining significantly from reporting year 2018 to reporting year 2019 for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure and develop strategies, as applicable, to address the significant decline in performance.	In reporting year 2019, SCFHP had a data gap for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure. SCFHP was not receiving lab value results for the HbA1c tests. Another contributing factor was that the majority of members in the sample pull population either did not have a lab value result or the test was done outside the measurement year. When reviewing past years' rates, we can see that reporting year 2019 was the only year that deviated from the MCP's consistent performance. For reporting year 2020 we had a significant improvement in performance due to an increase in clean and complete administrative lab data from our provider networks.

Assessment of MCP's Self-Reported Actions

HSAG reviewed SCFHP's self-reported actions in Table 8.1 and determined that SCFHP adequately addressed HSAG's recommendations from the MCP's July 1, 2018, through June 30, 2019, MCP-specific evaluation report. While SCFHP has not fully resolved all findings from the A&I 2019 Medical and State Supported Services Audits, the MCP indicated it is diligently working with DHCS to resolve all findings by the end of calendar year 2020. SCFHP also summarized the causes for the MCP's performance declining significantly from reporting year 2018 to reporting year 2019 for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure and indicated that the measure's rate significantly improved in reporting year 2020 due to improved data quality and completeness from the MCP's provider networks.

2019–20 Recommendations

Based on the overall assessment of SCFHP's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the MCP:

- Work with DHCS to fully resolve the findings from the 2019 and 2020 Medical Audits.
- Update the MCP's process to implement calculations that verify dual eligibility in monthly enrollment spans and to ensure that dual eligible members are being appropriately included and excluded using each measure's continuous enrollment criteria.
- Monitor the adapted intervention to achieve optimal outcomes beyond the life of the 2017–19 *Childhood Immunization Status—Combination 3* Disparity PIP.
- Apply the lessons learned from both 2017–19 PIPs to facilitate improvement for future PIPs.

In the next annual review, the EQRO will evaluate continued successes of SCFHP as well as the MCP's progress with these recommendations.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix EE:
Performance Evaluation Report
SCAN Health Plan
July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the PIHP with a specialized population as an SHP. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted PSP, SCAN Health Plan ("SCAN" or "the PSP"). The purpose of this appendix is to provide PSP-specific results of each activity and an assessment of the PSP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this PSP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in SCAN's 2020–21 PSP-specific evaluation report. This PSP-specific evaluation report references activities and methodologies described in detail in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

SCAN is a full-scope MCP delivering services to beneficiaries with specialized health care needs under the PSP model in Los Angeles, Riverside, and San Bernardino counties.

SCAN is a Medicare Advantage Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) that contracts with DHCS to provide services for the dual-eligible Medicare/Medi-Cal population subset residing in Los Angeles, Riverside, and San Bernardino counties. SCAN provides all services in the Medi-Cal State Plan, including home- and community-based services, to SCAN members assessed at the nursing facility-level of care and in nursing home custodial care. SCAN members must be at least 65 years of age, live in the service area, have Medicare Parts A and B, and have full-scope Medi-Cal with no share of cost. SCAN does not enroll individuals with end-stage renal disease.

SCAN has been licensed in California since November 30, 1984, in accordance with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, and became operational to provide MCMC services in Los Angeles County effective 1985. The PSP expanded into Riverside and San Bernardino counties in 1997.

In 2006, DHCS, at the direction of CMS, designated SCAN as an MCP. SCAN then functioned as a social health maintenance organization (HMO) under a federal waiver which expired at the end of 2007.

In 2008, SCAN entered a comprehensive risk contract with the State. SCAN receives monthly capitation from both Medicare and Medi-Cal, pooling its financing to pay for all services. DHCS amended SCAN's contract in 2008 to include the same federal and State requirements that exist for MCPs.

As of June 2020, SCAN had 9,762 members in Los Angeles County, 2,544 in Riverside County, and 1,784 in San Bernardino County—for a total of 14,090 members in the three counties combined.[1]

DHCS allows SCAN to combine data for Los Angeles, Riverside, and San Bernardino counties for reporting purposes. For this report, these three counties are considered a single reporting unit.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report.

Compliance Reviews Conducted

The following is a summary of the most recent reviews conducted for SCAN.

Table 2.1 summarizes the results and status of the on-site DHCS Audits & Investigations Division (A&I) Medical Audit of SCAN. A&I conducted the audit from March 2, 2020, through March 11, 2020. DHCS issued the final closeout letter on July 28, 2020, which is outside the review period for this report; however, HSAG includes the information from the letter because it reflects full resolution of the findings from the March 2020 A&I Medical Audit.

Table 2.1—DHCS A&I Medical Audit of SCAN
Audit Review Period: March 1, 2019, through February 29, 2020

Category Evaluated	Findings (Yes/No)	Monitoring Status
Utilization Management	No	No findings.
Case Management and Coordination of Care	No	No findings.
Access and Availability of Care	No	No findings.
Member's Rights	Yes	Corrective action plan (CAP) imposed and findings in this category rectified.
Quality Management	No	No findings.
Administrative and Organizational Capacity	No	No findings.

Strengths—Compliance Reviews

A&I identified a finding in only one category (Member's Rights) during the March 2020 Medical Audit of SCAN. In response to the CAP from this audit, SCAN submitted documentation to DHCS that resulted in the CAP being closed. The documentation outlined the PSP's new process for ensuring member grievance acknowledgement and resolution letters are written at the required sixth-grade reading level.

Opportunities for Improvement—Compliance Reviews

SCAN has no outstanding findings from the March 2020 A&I Medical Audit; therefore, HSAG has no recommendations for the PSP in the area of compliance reviews.

3. Population-Specific Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by PSPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with PSPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require PSPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by PSPs.

Hybrid Measure Reporting

PSPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to PSP and provider staff members related to COVID-19, DHCS allowed PSPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- ♦ Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- ♦ Report the measurement year 2018 audited hybrid rates, if available (i.e., the PSP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- ♦ Report the hybrid rates using measurement year 2019 administrative data only.

SCAN chose to report all hybrid measures according to the reporting year 2020 measure specifications using measurement year 2019 data.

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

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[2] The reporting year is the year in which PSPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

[3] HEDIS® is a registered trademark of NCQA.

[4] HEDIS Compliance Audit™ is a trademark of NCQA.

DHCS-Established Performance Levels

To assess performance for each PSP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for select MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold PSPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all PSPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold PSPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all PSPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. PSPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow PSPs flexibility regarding the Plan-Do-Study-Act (PDSA) cycle format and interventions. PSPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the PSP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. PSPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the PSP contracts authorize DHCS to impose sanctions on PSPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding PSPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

[5] Quality Compass® is a registered trademark of NCQA.

Performance Measure Validation Results

HSAG conducted an independent audit of SCAN, and the *HEDIS 2020 Compliance Audit Final Report of Findings for SCAN Health Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that SCAN followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results

After validating the PSP's performance measure rates, HSAG assessed the results. See Table 3.1 for SCAN's performance measure results for reporting year 2020.

Note the following regarding Table 3.1:

- ♦ The table presents reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 PSP-specific evaluation reports and trending beginning in the 2021–22 PSP-specific evaluation reports.
- ♦ Based on DHCS not holding PSPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the PSP's reporting year 2020 performance measure results.

Table 3.1—Reporting Year 2020 Performance Measure Results
SCAN—Los Angeles/Riverside/San Bernardino Counties

* A lower rate indicates better performance for this measure.

Measure	Reporting Year 2020 Rate
Women's Health Domain	
Breast Cancer Screening—Total	83.48%
Behavioral Health Domain	
Screening for Depression and Follow-Up Plan—Ages 65+ Years	17.81%
Acute and Chronic Disease Management Domain	
Adult BMI Assessment—Total	98.78%

Measure	Reporting Year 2020 Rate
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total**	14.11%
Comprehensive Diabetes Care—HbA1c Testing—Total	94.89%
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years**	13.27%
Controlling High Blood Pressure—Total	70.32%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years**	1.94%

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, SCAN will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the PSP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Strengths—Performance Measures

The HSAG auditor determined that SCAN followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Opportunities for Improvement—Performance Measures

Based on DHCS not holding PSPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability.

2017–19 Performance Improvement Projects

While MCPs, PSPs, and the SHP concluded their 2017–19 PIPs through the SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim end date of June 30, 2019, MCPs, PSPs, and the SHP submitted final modules for HSAG to validate during the review period for this report. HSAG assessed the validity and reliability of the results based on CMS' validation protocols to determine whether key stakeholders can have confidence in the reported PIP findings. HSAG assigned the following final confidence levels for each PIP:

- High confidence—the PIP was methodologically sound and achieved the SMART Aim goal; the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested; and the MCP, PSP, or SHP accurately summarized the key findings.
- Confidence—the PIP was methodologically sound and achieved the SMART Aim goal, and the MCP, PSP, or SHP accurately summarized the key findings. However, some, but not all, of the quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- Low confidence—either (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible (referred to in this report as "not credible")—the PIP methodology was not executed as approved.

2019–21 Performance Improvement Projects

Based on HSAG's annual review of the rapid-cycle PIP process, HSAG released the Rapid-Cycle PIP Version 5 in September 2019. While HSAG's rapid-cycle PIP process still requires extensive up-front preparation to allow for a structured, scientific approach to quality improvement, the updated version more efficiently guides MCMC plans through the process to provide more time for them to test interventions.

The following provides an overview of the Rapid-Cycle PIP Version 5 modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention

needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, SCAN submitted final modules for its 2017–19 Disparity and PSP-specific PIPs. HSAG provided final validation findings and encouraged the PSP to incorporate the experiences and lessons learned from the PIPs into future quality improvement efforts. HSAG includes the final PIP validation findings in this report.

Additionally, SCAN initiated the 2019–21 Health Equity and PSP-specific PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the PSP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2017–19 Disparity Performance Improvement Project

DHCS required SCAN to conduct a PIP focusing on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. Using its own PSP-specific data, SCAN identified statin use among members living with diabetes in San Bernardino County as its 2017–19 Disparity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

Table 4.1 provides the SMART Aim measure results reported by the PSP for its *Statin Use in Persons with Diabetes* Disparity PIP.

Table 4.1—SCAN *Statin Use in Persons with Diabetes* Disparity PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of statin utilization among members ages 40 to 75 diagnosed with diabetes and residing in San Bernardino County	77.02%	82.46%	No

Table 4.2 presents a description of the intervention that SCAN tested for its *Statin Use in Persons with Diabetes* Disparity PIP. The table also indicates the key drivers that the intervention addressed and whether the PSP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.2—SCAN *Statin Use in Persons with Diabetes* Disparity PIP Intervention Testing Results

Intervention	Key Drivers Addressed	Adopt, Adapt, Abandon, or Continue Testing
Conduct targeted outreach to members and their providers to provide education and reminders to increase statin use in members living with diabetes	♦ Frequency of prescriptions ♦ Member engagement and compliance with a treatment plan for medication management and adherence ♦ Member knowledge of medication and reason for the prescription	Adapt

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for SCAN's *Statin Use in Persons with Diabetes* Disparity PIP. In the modules, SCAN documented that it tested having trained nurses conduct the telephonic outreach to targeted members who had not refilled their statin prescriptions to provide medication adherence education and to identify and assist with reducing barriers. The nurses also contacted the members' prescribing providers to notify the providers of the members' need for filling the statin prescriptions and offer assistance with appointment scheduling. While SCAN did not achieve the SMART Aim goal, the PSP determined to adapt the intervention as it recognized the tremendous value of nurses contacting both members and their providers to ensure coordination of member education and appointment scheduling are completed successfully. SCAN will apply lessons learned from the intervention and continue to test the outreach intervention to improve targeted members' statin medication adherence.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned SCAN's *Statin Use in Persons with Diabetes* Disparity PIP a final confidence level of *Low Confidence*.

2017–19 Cholesterol Medication Adherence Performance Improvement Project

SCAN selected cholesterol medication adherence for its 2017–19 PSP-specific PIP topic based on its PSP-specific data.

Table 4.3 provides the SMART Aim measure results as reported by the PSP for its *Cholesterol Medication Adherence* PIP.

Table 4.3—SCAN *Cholesterol Medication Adherence* PIP SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	SMART Aim Goal Achieved
Rate of statin medication adherence among members ages 18 and older who are prescribed statin medications and assigned to Provider A[6]	80.26%	84.16%	No

Table 4.4 presents a description of the intervention that SCAN tested for its *Cholesterol Medication Adherence* PIP. The table also indicates the failure modes that the intervention addressed and whether the PSP decided, based on intervention testing results, to adopt, adapt, abandon, or continue testing the intervention.

Table 4.4—SCAN *Cholesterol Medication Adherence* PIP Intervention Testing Results

Intervention	Failure Modes Addressed	Adopt, Adapt, Abandon, or Continue Testing
Conduct person-to-person telephonic outreach to assess barriers, provide education on medication adherence, and facilitate removing barriers as needed	♦ Members not convinced of the importance and value of a 90-day medication supply ♦ Members understand the 90-day supply benefit but cannot afford it ♦ Members forget about getting a refill on time ♦ Members are not out of medication due to not taking the prescribed amount	Continue Testing

Performance Improvement Project Validation Findings

During the review period for this report, HSAG validated modules 4 and 5 for SCAN's *Cholesterol Medication Adherence* PIP. In the modules, SCAN documented that it tested having care management staff members conduct person-to-person telephonic outreach calls to members identified as non-adherent or at risk of non-compliance for their cholesterol medications. The PSP staff members used a person-centered approach to identify members' needs and personal barriers in order to provide targeted education to improve members' medication adherence. SCAN did not achieve the SMART Aim goal; however, the PSP

[6] Provider name removed for confidentiality.

indicated that it will continue to test the intervention to determine the feasibility of incorporating the outreach calls into the care management team's existing program to assist people with complex health and social needs.

Upon assessment of the validity and reliability of the PIP results, HSAG assigned SCAN's *Cholesterol Medication Adherence* PIP a final confidence level of *Low Confidence*.

2019–21 Health Equity Performance Improvement Project

During the review period, DHCS required PSPs to conduct a PIP focusing on an identified health disparity. While DHCS did not require the identified health disparity to be related to the reporting year 2020 MCAS, DHCS strongly encouraged PSPs to select a health disparity related to an MCAS measure for which they are not performing well. Additionally, DHCS encouraged PSPs to continue with their 2017–19 Disparity PIP topic if the data showed that the health disparity still exists.

Using its own PSP-specific data, SCAN identified improving diabetes control among Spanish-speaking members as its 2019–21 Health Equity PIP topic by demonstrating a statistically significant rate difference between two subgroups, with the disparate subgroup having the lower rate.

During the review period of this report, HSAG validated modules 1 and 2 for the PSP's *Diabetes Control* Health Equity PIP. Upon initial review of the modules, HSAG determined that SCAN met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of:
  - The SMART Aim statement.
  - The SMART Aim data collection methodology.
  - The SMART Aim run chart.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Labeling clearly the identified gaps or opportunities for improvement in the process map steps.
- Aligning the steps documented in the Failure Modes and Effects Analysis Table with the steps in the process map that were identified as gaps or opportunities for improvement.
- Prioritizing the listed failure modes and ranking them from highest to lowest in the Failure Mode Priority Ranking Table.

After receiving technical assistance from HSAG, SCAN incorporated HSAG's feedback into modules 1 and 2. Upon final review, HSAG determined that the PSP met all validation criteria for modules 1 and 2. SCAN was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Breast Cancer Screening Performance Improvement Project

SCAN selected breast cancer screening for its 2019–21 PSP-specific PIP topic based on its PSP-specific data.

During the review period for this report, HSAG validated modules 1 and 2 for the PSP's *Breast Cancer Screening* PIP. Upon initial review of Module 1, HSAG determined that SCAN met some required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of:

- The SMART Aim statement.
- The SMART Aim data collection methodology.
- The SMART Aim run chart.

After receiving technical assistance from HSAG, SCAN incorporated HSAG's feedback into Module 1. Upon final review, HSAG determined that the PSP met all validation criteria for Module 1. SCAN met all Module 2 validation criteria in its initial submission, and the PSP was in the process of working on its Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Upon completion of the 2017–19 PIPs, SCAN identified interventions that it can adapt and continue to test to improve medication adherence among members living with diabetes and high cholesterol.

Opportunities for Improvement—Performance Improvement Projects

SCAN has the opportunity to monitor the interventions it planned to adapt and continue to test in order to achieve optimal outcomes beyond the life of the 2017–19 PIPs. The PSP should apply lessons learned from these PIPs to facilitate improvement of the interventions and to strengthen future quality improvement efforts.

5. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the seniors and persons with disabilities population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

SCAN submitted the PSP's final PNA report to DHCS on August 20, 2020, and DHCS notified the PSP via email on August 21, 2020, that DHCS approved the report as submitted. While SCAN submitted the PNA report and DHCS sent the email outside the review period for this PSP-specific evaluation report, HSAG includes the information because it was available prior to this report being finalized.

6. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Based on HSAG's assessment of SCAN's delivery of quality, accessible, and timely care through the activities described in the PSP's 2018–19 PSP-specific evaluation report, HSAG included no recommendations in SCAN's 2018–19 PSP-specific evaluation report. Therefore, SCAN had no recommendations for which it was required to provide the PSP's self-reported actions.

2019–20 Recommendations

Based on the overall assessment of SCAN's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG recommends the following to the PSP:

- Monitor the interventions it planned to adapt and continue to test in order to achieve optimal outcomes beyond the life of the 2017–19 PIPs.
- Apply lessons learned from the 2017–19 PIPs to facilitate improvement of the interventions and to strengthen future quality improvement efforts.

In the next annual review, the EQRO will evaluate continued successes of SCAN as well as the PSP's progress with these recommendations.

Medi-Cal Managed Care External Quality Review Technical Report

Appendix FF: Performance Evaluation Report UnitedHealthcare Community Plan

July 1, 2019–June 30, 2020

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1. Introduction

The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual independent technical report in accordance with 42 Code of Federal Regulations (CFR) Section (§)438.364. The *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020,* provides an overview of the objectives and methodology for conducting the external quality review (EQR) activities of DHCS' Medi-Cal Managed Care program (MCMC), including requirements related to each activity. Additionally, the technical report provides aggregated results and recommendations for DHCS for each activity.

In accordance with 42 CFR §438.350, each state must have its EQRO perform an annual EQR of each of the state's managed care entities engaged in EQR activities. Title 42 CFR §438.2 defines a managed care organization (MCO), in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted managed care health plans (MCPs) as MCOs and dental managed care plans (DMC plans) as prepaid ambulatory health plans (PAHPs). Three of DHCS' MCOs are designated as population-specific health plans (PSPs). MCMC has one prepaid inpatient health plan (PIHP) with a specialized population, which is designated as a specialty health plan (SHP). Unless citing Title 42 CFR, HSAG refers to DHCS' MCOs as MCPs or PSPs (as applicable), PAHPs as DMC plans, and the PIHP with a specialized population as an SHP. Additionally, HSAG will sometimes collectively refer to these Medi-Cal managed care plans as "MCMC plans."

This appendix is specific to DHCS' contracted MCP, UnitedHealthcare Community Plan ("UHC" or "the MCP"). The purpose of this appendix is to provide MCP-specific results of each activity and an assessment of the MCP's strengths and opportunities for improvement with respect to the quality and timeliness of, and access to health care services furnished to its members. In this report, the term "beneficiary" refers to a person entitled to receive benefits under MCMC, and the term "member" refers to a person enrolled in an MCMC plan. The review period for this MCP-specific evaluation report is July 1, 2019, through June 30, 2020. The EQRO will report on activities that take place beyond the review period in UHC's 2020–21 MCP-specific evaluation report. This MCP-specific evaluation report references activities and methodologies described in detail in the technical report section.

The aggregate EQR technical report and plan-specific performance evaluation reports reflect HSAG's external, independent assessment of the quality and timeliness of, and access to health care that MCMC plans are providing to their members.

Note that beginning in March 2020, DHCS allowed MCMC plans flexibility related to select EQR activities so that MCMC plans and their contracted providers could focus on the coronavirus disease 2019 (COVID-19) response efforts. Additionally, DHCS changed its requirements related to some EQR activities. As applicable in this report related to specific activities, HSAG notes when DHCS halted EQR activities or changed its requirements due to

the COVID-19 response. For details regarding all of DHCS' COVID-19-related decisions, go to DHCS COVID-19 Response.

Medi-Cal Managed Care Health Plan Overview

UHC is a full-scope MCP delivering services to its members under a Geographic Managed Care (GMC) model. Although the GMC model operates in the counties of San Diego and Sacramento, UHC only operates in San Diego County. In the GMC model, DHCS allows beneficiaries to select from several commercial MCPs within the specified geographic service area (county).

In addition to UHC, San Diego County's beneficiaries may select from the following MCPs:

- Aetna Better Health of California
- Blue Shield of California Promise Health Plan (known as Care1st Partner Plan prior to January 1, 2019)
- Community Health Group Partnership Plan
- Health Net Community Solutions, Inc.
- Kaiser SoCal
- Molina Healthcare of California

UHC became operational in San Diego County to provide MCMC services effective October 1, 2017. As of June 2020, UHC had 14,983 members.[1] This represents 2 percent of the beneficiaries enrolled in San Diego County.

[1] California Health & Human Services Agency. *Medi-Cal Managed Care Enrollment Report*. Available at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment numbers are based on June 2020 enrollment information from the report downloaded on Jul 15, 2020.

2. Compliance Reviews

A description of DHCS' compliance review activity, as well as descriptions of the two types of reviews, may be found within the main section of this technical report. Due to the COVID-19 response efforts, in April 2020, DHCS Audits & Investigations Division (A&I) suspended its Medical and State Supported Services Audits of MCPs; however, DHCS continued to require MCPs to comply with all corrective action plan (CAP) requirements imposed prior to COVID-19. UHC's audit was cancelled based on A&I's decision; therefore, HSAG includes no 2020 compliance review information for the MCP in this report.

Follow-Up on 2019 A&I Medical and State Supported Services Audits

A&I conducted Medical and State Supported Services Audits of UHC from May 28, 2019, through June 7, 2019. HSAG provided a summary of the audit results and status in UHC's 2018–19 MCP-specific evaluation report. At the time the evaluation report was published, UHC's CAP was in process and under review by DHCS. A letter dated July 14, 2020, stated that UHC provided DHCS with additional information regarding the CAP, and that DHCS had reviewed the information and closed the CAP. The letter indicated that DHCS would monitor the MCP's full implementation of the CAP during the subsequent audit.

Strengths—Compliance Reviews

In response to the CAP from the 2019 A&I Medical and State Supported Services Audits, UHC submitted documentation to DHCS regarding the actions the MCP took to resolve the findings DHCS identified during the audits. UHC's submitted documentation resulted in DHCS closing the CAP.

Opportunities for Improvement—Compliance Reviews

UHC has no outstanding findings from the 2019 A&I Medical and State Supported Services Audits; therefore, HSAG has no recommendations for the MCP in the area of compliance reviews.

3. Managed Care Health Plan Performance Measures

Performance Measures Overview

DHCS selects a set of performance measures to evaluate the quality of care delivered by MCPs to their members. Beginning with reporting year[2] 2020, DHCS modified this performance measure set, which it now calls the Managed Care Accountability Set (MCAS). MCAS includes only select CMS Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets), some of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measures. DHCS consults with MCPs, HSAG, and stakeholders to determine which CMS Core Set measures DHCS will require MCPs to report. DHCS contracted with HSAG to conduct an independent audit, in alignment with the National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™,[4] standards, policies, and procedures, to assess the validity of HEDIS and non-HEDIS MCAS performance measures calculated and submitted by MCPs.

Hybrid Measure Reporting

MCPs are required to procure medical record data for performance measures reported using the hybrid methodology. In April 2020, due to travel restrictions, quarantines, and potential risk to MCP and provider staff members related to COVID-19, DHCS allowed MCPs the following three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to the NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Appendix GG includes tables that display all MCP reporting units and hybrid measures for those MCPs that chose to report rates using measurement year 2018 audited hybrid rates or using measurement year 2019 administrative data only. Please refer to this appendix to see the reporting units and measures UHC chose to report using one or both of these two options.

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[2] The reporting year is the year in which MCPs report the rates. The reporting year rates reflect measurement year data from the previous calendar year.

[3] HEDIS® is a registered trademark of NCQA.

[4] HEDIS Compliance Audit™ is a trademark of NCQA.

Note: All reporting year 2020 administrative measure rates reflect measurement year data from January 1, 2019, through December 31, 2019.

DHCS-Established Performance Levels

To assess performance for each MCP reporting unit, HSAG compares the rates to DHCS-established performance levels that are based on national benchmarks. The high performance levels and minimum performance levels represent the NCQA Quality Compass®[5] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively. DHCS initially established minimum performance levels for 13 hybrid and five administrative MCAS measures for reporting year 2020; however, due to COVID-19, DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any measures. Instead, DHCS required all MCPs to conduct specific quality improvement activities as described under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section.

Reporting Year 2019 HEDIS Improvement Plan Process

For reporting year 2019 performance measures with rates below the DHCS-established minimum performance levels, DHCS required MCPs to submit to DHCS improvement plans (IPs). IPs generally consisted of submitting Plan-Do-Study-Act (PDSA) Cycle Worksheets; however, if an MCP was already conducting a performance improvement project (PIP) for a measure with a rate below the minimum performance level, DHCS did not require the MCP to also conduct IP PDSA cycles and submit PDSA Cycle Worksheets for the measure. Additionally, when DHCS determined that a more systematic intervention was warranted, DHCS approved the MCP to conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis as an alternative quality improvement activity. Note that the IP requirements do not apply to new MCPs or newly created regions.

Reporting Year 2019 Corrective Action Plans

For reporting year 2019, DHCS required a CAP for MCPs that had multiple measures with rates below the minimum performance levels, or when DHCS determined that a CAP was necessary. CAP requirements included, but were not limited to:

- Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities.
- Additional technical assistance calls with DHCS Nurse Consultant staff.
- In-person meetings with MCP and DHCS executive staff members.

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[5] Quality Compass® is a registered trademark of NCQA.

Reporting Year 2020 Quality Monitoring and Corrective Action Plans

While DHCS determined not to hold MCPs accountable to meet the minimum performance levels for any of the reporting year 2020 MCAS measures, DHCS required that all MCPs:

- Conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19. MCPs must provide evidence to support their measure choice. DHCS noted that to accommodate barriers related to COVID-19, DHCS will allow MCPs flexibility regarding the PDSA cycle format and interventions. MCPs are required to submit PDSA cycle information to DHCS using DHCS' PDSA Cycle Worksheet.
- Develop and submit to DHCS a brief COVID-19 Quality Improvement Plan (QIP) that includes a description of the MCP's strategies or interventions aimed at increasing the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19. MCPs are required to submit an initial COVID-19 QIP and a six-month progress update.

Sanctions

California Welfare and Institutions Code (CA WIC) §14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required minimum performance levels on any of the applicable MCAS measures in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified. Note that based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure, DHCS will not impose any sanctions based on reporting year 2020 performance measure results.

Performance Measure Validation Results

HSAG conducted an independent audit of UHC, and the *HEDIS 2020 Compliance Audit Final Report of Findings for UnitedHealthcare Community Plan* contains the detailed findings and recommendations from the audit.

The HSAG auditor determined that UHC followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. See Table 3.1 through Table 3.4 for UHC's performance measure results for reporting year 2020.

Note the following regarding Table 3.1 through Table 3.4:

- To allow HSAG to provide meaningful assessment of MCP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- The tables present reporting year 2020 rates only, based on DHCS making changes to performance measure requirements and age stratifications from the previous reporting year. The EQRO will display performance measure rate comparisons in the 2020–21 MCP-specific evaluation reports and trending beginning in the 2021–22 MCP-specific evaluation reports.
- Based on DHCS not holding MCPs accountable to meet minimum performance levels for any measures, HSAG only presents the performance measure results and does not make conclusions or recommendations related to the MCP's reporting year 2020 performance measure results.

Children's Health Domain

Table 3.1 presents the reporting year 2020 performance measure rates within the Children's Health domain.

Table 3.1—Children's Health Domain
Reporting Year 2020 Performance Measure Results
UHC—San Diego County

Measure	Reporting Year 2020 Rate
Adolescent Well-Care Visits	41.12%
Childhood Immunization Status—Combination 10	27.27%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months	74.12%
Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years	55.92%
Children and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years	80.95%
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	64.81%
Developmental Screening in the First Three Years of Life—Total	23.50%
Immunizations for Adolescents—Combination 2	29.82%

Measure	Reporting Year 2020 Rate
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	86.13%
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	44.68%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	59.15%

Women's Health Domain

Table 3.2 presents the reporting year 2020 performance measure rates within the Women's Health domain.

Table 3.2—Women's Health Domain
Reporting Year 2020 Performance Measure Results
UHC—San Diego County

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Breast Cancer Screening—Total	NA
Cervical Cancer Screening	50.61%
Chlamydia Screening in Women—Ages 16–20 Years	66.67%
Chlamydia Screening in Women—Ages 21–24 Years	69.68%
Chlamydia Screening in Women—Total	68.57%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years	19.92%
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	28.67%
Contraceptive Care—All Women—LARC—Ages 15–20 Years	S
Contraceptive Care—All Women—LARC—Ages 21–44 Years	6.80%

Measure	Reporting Year 2020 Rate
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years	8.94%
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	37.99%
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—3 Days—Ages 21–44 Years	S
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 15–20 Years	NA
Contraceptive Care—Postpartum Women—LARC—60 Days—Ages 21–44 Years	8.94%
Prenatal and Postpartum Care—Postpartum Care	74.87%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.01%

Behavioral Health Domain

Table 3.3 presents the reporting year 2020 performance measure rates within the Behavioral Health domain.

Table 3.3—Behavioral Health Domain
Reporting Year 2020 Performance Measure Results
UHC—San Diego County

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	63.30%

Measure	Reporting Year 2020 Rate
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	41.28%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	NA
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	NA
Screening for Depression and Follow-Up Plan—Ages 12–17 Years	6.88%
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	8.24%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	5.91%

Acute and Chronic Disease Management Domain

Table 3.4 presents the reporting year 2020 performance measure rates within the Acute and Chronic Disease Management domain.

Table 3.4—Acute and Chronic Disease Management Domain
Reporting Year 2020 Performance Measure Results
UHC—San Diego County

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

S = Fewer than 11 cases exist in the numerator of this measure; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

Measure	Reporting Year 2020 Rate
Adult BMI Assessment—Total	93.19%
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	42.45
Asthma Medication Ratio—Total	NA

Measure	Reporting Year 2020 Rate
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total***	33.65%
Comprehensive Diabetes Care—HbA1c Testing—Total	85.78%
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years***	S
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years***	NA
Controlling High Blood Pressure—Total	64.44%
HIV Viral Load Suppression—Ages 18–64 Years	18.33%
HIV Viral Load Suppression—Ages 65+ Years	NA
*Plan All-Cause Readmissions—Observed Readmissions—Total***	NA
Plan All-Cause Readmissions—Expected Readmissions—Total	NA
*Plan All-Cause Readmissions—O/E Ratio—Total***	NA
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years***	0.00%
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years***	NA

Quality Monitoring and Corrective Action Plan Requirements for 2020

As stated under the "Reporting Year 2020 Quality Monitoring and Corrective Action Plans" heading in this section, UHC will be required to conduct PDSA cycles on one MCAS measure that focuses on preventive care, chronic disease management, or behavioral health and has been impacted by COVID-19, as well as to develop and submit a COVID-19 QIP that briefly describes the MCP's strategies or interventions to increase the provision of preventive services, chronic disease care, and/or behavioral health services for members amidst COVID-19.

Seniors and Persons with Disabilities Results and Findings

Seniors and Persons with Disabilities—Performance Measure Results

Table 3.5 presents the reporting year 2020 seniors and persons with disabilities (SPD) and non-SPD rates, a comparison of the SPD and non-SPD rates, and the total combined rate for each measure. Reporting year 2020 rates reflect measurement year data from January 1, 2019, through December 31, 2019.

Table 3.5—Reporting Year 2020 (Measurement Year 2019) Performance Measure Comparison and Results for Measures Stratified by the SPD and Non-SPD Populations UHC—San Diego County

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly better than the reporting year 2020 non-SPD rate.

= Statistical testing result indicates that the reporting year 2020 SPD rate is significantly worse than the reporting year 2020 non-SPD rate.

Performance comparisons are based on the Chi-square test of statistical significance, with a *p* value of <0.05.

The reporting year 2020 total rates are based on the MCP reporting unit's total results, including the SPD and non-SPD populations. Please note, if data are not available for either the SPD or non-SPD population, the total rate is based on results reported for the available population.

* This is a utilization measure which measures the volume of services used; therefore, a high or low rate does not necessarily indicate better or worse performance. Additionally, member months are a member's "contribution" to the total yearly membership.

** A lower rate indicates better performance for this measure.

NA = The MCP followed the specifications, but the denominator was too small (less than 30) to report a valid rate.

Not Comparable = An SPD/non-SPD rate difference cannot be made because data are not available for both populations.

Not Tested = An SPD/non-SPD rate difference was not calculated because higher or lower rates do not necessarily indicate better or worse performance.

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
*Ambulatory Care—ED Visits per 1,000 Member Months—Total**	72.79	41.19	Not Tested	42.45

Measure	Reporting Year 2020 SPD Rate	Reporting Year 2020 Non-SPD Rate	SPD/Non-SPD Rate Difference	Reporting Year 2020 Total Rate
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–24 Months	NA	74.45%	Not Comparable	74.12%
Children and Adolescents' Access to Primary Care Practitioners— Ages 25 Months–6 Years	NA	57.04%	Not Comparable	55.92%
Children and Adolescents' Access to Primary Care Practitioners— Ages 7–11 Years	NA	84.62%	Not Comparable	80.95%
Children and Adolescents' Access to Primary Care Practitioners— Ages 12–19 Years	NA	66.04%	Not Comparable	64.81%
*Plan All-Cause Readmissions— Total***	NA	NA	Not Comparable	NA

Seniors and Persons with Disabilities—Performance Measure Findings

HSAG was unable to compare the reporting year 2020 SPD and non-SPD rates due to all SPD rates having denominators too low for UHC to report valid rates.

Strengths—Performance Measures

The HSAG auditor determined that UHC followed the appropriate specifications to produce valid rates, and the auditor identified no issues of concern.

Opportunities for Improvement—Performance Measures

Based on DHCS not holding MCPs accountable to meet the minimum performance level for any measure in reporting year 2020, HSAG identified no opportunities for improvement related to performance measure results.

4. Managed Long-Term Services and Supports Plan Performance Measures

Due to UHC's participation in California's Coordinated Care Initiative (CCI) as a Managed Long-Term Services and Supports Plan (MLTSSP), DHCS required that UHC report rates for four HEDIS measures for HSAG to validate as part of the HEDIS Compliance Audit. Note that DHCS does not hold MLTSSPs accountable to meet minimum performance levels for the required measures.

While UHC participates in the CCI as an MLTSSP in San Diego County, in reporting year 2020 UHC had no members in San Diego County who met the MLTSS measure reporting criteria; therefore, UHC has no reporting year 2020 MLTSS rates for San Diego County.

5. Performance Improvement Projects

Performance Improvement Project Overview

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions using quality improvement tools, conducting PDSA cycles to test interventions, and planning for the spread of successful changes. The core component of the rapid-cycle PIP approach involves testing changes on a small scale so that improvement can occur more efficiently and lead to long-term sustainability.

2019–21 Performance Improvement Projects

The following provides an overview of the Rapid-Cycle PIP modules:

- Module 1—PIP Initiation
  - MCMC plans outline the framework for the PIP, which includes the:
    - Topic rationale.
    - Narrowed focus description.
    - SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim measure baseline data collection specifications and methodology.
    - SMART Aim statement.
    - SMART Aim run chart.
- Module 2—Intervention Determination
  - MCMC plans define the quality improvement activities that have the potential to impact the SMART Aim by using the following quality improvement tools:
    - Process mapping.
    - Failure modes and effects analysis.
    - Key driver diagram.
- Module 3—Intervention Testing
  - MCMC plans define the Intervention Plan for the intervention to be tested.
  - MCMC plans test and evaluate the intervention through a series of PDSA cycles.
- Module 4—PIP Conclusions
  - MCMC plans interpret results and summarize:
    - Key findings and outcomes achieved.
    - The assessment of each tested intervention.
    - Lessons learned, including how demonstrated improvement can be shared and used as a foundation for further improvement going forward.
    - The plan for sustained improvement, if applicable.

Based on the agreed-upon timeline, MCMC plans submit each module to HSAG for validation. Throughout the rapid-cycle PIP process, HSAG provides technical assistance to MCMC plans to ensure that PIPs are methodologically sound and to problem-solve with the plans regarding how to address challenges that occur. Through an iterative process, MCMC plans have opportunities to make corrections to modules 1 through 3 to achieve all validation criteria.

Once MCMC plans achieve all validation criteria for modules 1 through 3, the MCMC plans test interventions through a series of PDSA cycles. During the intervention testing phase of the PIP, HSAG conducts periodic progress check-ins by email to ensure that MCMC plans are making appropriate progress with intervention testing. For each intervention testing cycle, MCMC plans complete a PDSA worksheet and determine the next steps based on results and lessons learned—whether the intervention was successful and should be spread (adopt), whether modifications need to be made to the existing intervention (adapt), whether the intervention was unsuccessful and should be stopped (abandon), or whether the intervention needs to be tested further (continue testing). Upon completion of the PIP, MCMC plans summarize the overall PIP in Module 4.

Performance Improvement Project Results and Findings

During the review period, UHC initiated two 2019–21 PIPs. While the original SMART Aim end date for the 2019–21 PIPs was June 30, 2021, due to challenges MCMC plans experienced in conducting PIP activities during the COVID-19 public health crisis, DHCS elected to end the 2019–21 PIPs effective June 30, 2020. In this report, HSAG includes summaries of the MCP's module submissions for the 2019–21 PIPs as well as validation findings from the review period.

2019–21 Cervical Cancer Screening Performance Improvement Project

For one of the two 2019–21 PIPs, DHCS required MCPs to conduct a Health Equity PIP focusing on an identified health disparity; however, based on UHC beginning its MCMC services on October 1, 2017, the MCP did not have enough data to demonstrate an identified health disparity. Instead, UHC provided data to support the need to improve the *Cervical Cancer Screening* measure rate; therefore, DHCS approved UHC to conduct its 2019–21 Health Equity PIP on cervical cancer screening for the MCP's entire member population.

During the review period of this report, HSAG validated modules 1 and 2 for the MCP's 2019–21 *Cervical Cancer Screening* PIP. Upon initial review of Module 1, HSAG determined that UHC met some required validation criteria; however, HSAG identified opportunities for improvement related to including all required components of:

- The SMART Aim statement.
- The SMART Aim data collection methodology.
- The SMART Aim run chart.

After receiving technical assistance from HSAG, UHC incorporated HSAG's feedback into Module 1. Upon review, HSAG determined that UHC conditionally met Module 1 validation criteria since the MCP needed to update the SMART Aim measure baseline and goal rates once the final reporting year 2020 *Cervical Cancer Screening* measure rate became available. UHC met all Module 2 validation criteria in its initial submission, and the MCP was in the process of working on its Module 1 resubmission and Module 3 submission when DHCS determined to end the 2019–21 PIPs.

2019–21 Child and Adolescent Health Performance Improvement Project

DHCS required MCPs to conduct a PIP for an area in need of improvement related to child and adolescent health. Based on MCP-specific data, UHC selected well-child visits for children ages 3 to 6 as its 2019–21 Child and Adolescent Health PIP topic.

During the review period for this report, HSAG validated modules 1 and 2 for the MCP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. Upon initial review of the modules, HSAG determined that UHC met some required validation criteria; however, HSAG identified opportunities for improvement related to:

- Including all required components of:
  - The SMART Aim statement.
  - The SMART Aim data collection methodology.
  - The SMART Aim run chart.
- Including a process map that clearly illustrates the step-by-step flow of the current process for the narrowed focus.
- Linking logically the failure modes, failure causes, and failure effects to the steps in the Failure Modes and Effects Analysis Table.

After receiving technical assistance from HSAG, UHC incorporated HSAG's feedback into modules 1 and 2. Upon review, HSAG determined that UHC conditionally met Module 1 validation criteria since the MCP needed to update the SMART Aim measure baseline and goal rates once the final reporting year 2020 *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate became available. UHC met all validation criteria for Module 2, and the MCP was in the process of working on its Module 1 resubmission and Module 3 submission when DHCS determined to end the 2019–21 PIPs.

Strengths—Performance Improvement Projects

Using information gained from HSAG's PIP training, validation results, and technical assistance, UHC submitted all available PIP documentation as required.

Opportunities for Improvement—Performance Improvement Projects

Based on UHC's PIP progression, HSAG identified no opportunities for improvement in the area of PIPs.

6. Validation of Network Adequacy

Timely Access Focused Study

DHCS requires MCPs to ensure that their participating providers offer appointments that meet the wait time standards described in Table 6.1. During the review period, HSAG conducted the Timely Access Focused Study to evaluate the extent to which MCPs are meeting the wait time standards listed in Table 6.1.

Table 6.1—California Department of Health Care Services Timely Access Standards

Appointment Type	Wait Time Standard	
	Non-Urgent Appointments	Urgent Appointments
Primary care appointment (adult and pediatric)	10 business days	48 hours
Specialist appointment (adult and pediatric)	15 business days	96 hours
Appointment with a mental health care provider who is not a physician (adult and pediatric)	10 business days	96 hours
First prenatal visits	10 business days	Not Applicable
Appointment with ancillary providers	15 business days	Not Applicable

HSAG also evaluated the following:

- The extent to which providers are aware of interpretation service requirements.
- The extent to which the MCPs' call centers are meeting DHCS' 10-minute wait time standard and the call centers' knowledge of interpretation service requirements.

In March 2020, to ensure MCPs and their providers could prioritize COVID-19 response efforts, HSAG temporarily halted the Timely Access Focused Study. In July 2020, DHCS determined to cancel this study for the remainder of the calendar year to allow MCPs and their providers to continue prioritizing COVID-19 response efforts.

HSAG included Timely Access Focused Study results from calendar year 2018 and the first three quarters of 2019 in the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2018–June 30, 2019*. During the review period for this MCP-specific evaluation report, HSAG produced and submitted to DHCS quarterly reports and raw data files at the statewide aggregate and MCP levels for fourth quarter 2019. Section 14 of the *Medi-Cal*

Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020 ("Validation of Network Adequacy") provides a summary of the statewide aggregate results and conclusions from the Timely Access Focused Study.

DHCS' process includes providing quarterly MCP-level reports and raw data to each MCP and requires the MCP to provide via the Quality Monitoring Response Template a written response to DHCS regarding results that showed potential compliance issues, strategies to overcome any identified deficiencies, and a timeline for making needed corrections. DHCS reviews and provides feedback to each MCP and then determines whether or not the MCP is required to take further action. DHCS also uses the raw data files from the study to hold MCPs accountable to investigate and correct errors in their 274 provider data. Due to DHCS suspending the timely access survey calls in March 2020 to allow MCPs and providers to focus on COVID-19 response efforts, DHCS did not send quarterly MCP-level reports or raw data to MCPs and did not require any MCP responses for the remainder of the calendar year.

7. Population Needs Assessment

DHCS requires MCPs and PSPs to conduct a population needs assessment (PNA) to improve health outcomes for beneficiaries and ensure that MCPs and PSPs are meeting the needs of their members. The PNA must address the special needs of the SPD population, children with special health care needs, members with limited English proficiency, and other member subgroups from diverse cultural and ethnic backgrounds. MCPs and PSPs must use the PNA findings to identify opportunities for improvement and take action to address them. Section 19 of the *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2019–June 30, 2020* ("Population Needs Assessment") provides additional details regarding DHCS' PNA requirements and includes a summary of the PNAs across all MCPs and PSPs.

Status of Population Needs Assessment

UHC submitted the MCP's PNA report to DHCS on March 31, 2020, and DHCS notified the MCP via email on June 16, 2020, that DHCS had approved the report as submitted.

8. Recommendations

Follow-Up on Prior Year Recommendations

DHCS provided each MCP, PSP, and the SHP an opportunity to outline actions taken to address recommendations HSAG made in its 2018–19 MCP-/PSP-/SHP-specific evaluation report. Table 8.1 provides EQR recommendations from UHC's July 1, 2018, through June 30, 2019, MCP-specific evaluation report, along with the MCP's self-reported actions taken through June 30, 2020, that address the recommendations. Please note that HSAG made minimal edits to Table 8.1 to preserve the accuracy of UHC's self-reported actions.

Table 8.1—UHC's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2018, through June 30, 2019, MCP-Specific Evaluation Report

2018–19 External Quality Review Recommendations Directed to UHC	Actions Taken by UHC during the Period July 1, 2019–June 30, 2020, that Address the External Quality Review Recommendations
Work with DHCS to ensure that the MCP fully resolves all findings from the May 28, 2019, through June 7, 2019, Medical and State Supported Services Audits.	All findings from the 2019 Medical and State Supported Services Audits have been resolved.

Assessment of MCP's Self-Reported Actions

In Table 8.1, UHC confirmed that it resolved all findings from the 2019 Medical and State Supported Services Audits. While UHC did not provide specific details regarding the steps it took to resolve the findings, DHCS provided HSAG with the final audit closeout letter, which included the details regarding the documentation UHC submitted to DHCS to fully resolve all findings. UHC's submitted documentation resulted in DHCS closing the CAP.

2019–20 Recommendations

Based on the overall assessment of UHC's delivery of quality, accessible, and timely care through the activities described in previous sections of this report, HSAG has no recommendations for the MCP.

In the next annual review, the EQRO will evaluate continued successes of UHC.

Medi-Cal Managed Care
External Quality Review Technical Report

Appendix GG:
Alternate Reporting Methods for Reporting Year 2020 Hybrid Measures

July 1, 2019–June 30, 2020

Alternate Reporting Methods for Reporting Year 2020 Hybrid Measures

In April 2020, due to travel restrictions, quarantines, and potential risk to managed care health plan (MCP) and provider staff members related to the coronavirus disease 2019 (COVID-19), the California Department of Health Care Services (DHCS) allowed Medi-Cal Managed Care (MCMC) plans flexibility for hybrid measure reporting. Consistent with National Committee for Quality Assurance (NCQA) allowances, DHCS allowed those MCPs unable to report hybrid measure rates according to reporting year 2020 hybrid technical specifications using measurement year 2019 data to choose from the following two options for hybrid measure reporting:

- ♦ Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to NCQA as part of the health plan accreditation process).
- ♦ Report the hybrid rates using measurement year 2019 administrative data only.

Table 1 in this appendix displays the hybrid measures that MCPs chose to report using measurement year 2018 (reporting year 2019) data, by reporting unit. Table 2 displays the hybrid measures that MCPs chose to report using measurement year 2019 (reporting year 2020) administrative data only, by reporting unit.

Table 1—Reporting Year 2020 Hybrid Measures Reported Using Measurement Year 2018 Data

Managed Care Health Plan	Reporting Unit	Measures
Alameda Alliance for Health	Alameda County	♦ *Cervical Cancer Screening* ♦ *Controlling High Blood Pressure—Total* ♦ *Immunizations for Adolescents—Combination 2*
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Alameda County	♦ *Adult BMI Assessment—Total* ♦ *Controlling High Blood Pressure—Total* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Managed Care Health Plan	Reporting Unit	Measures
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Contra Costa County	♦ *Adult BMI Assessment—Total* ♦ *Cervical Cancer Screening* ♦ *Controlling High Blood Pressure—Total* ♦ *Prenatal and Postpartum Care—Postpartum Care* ♦ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Fresno County	♦ *Adult BMI Assessment—Total* ♦ *Cervical Cancer Screening* ♦ *Childhood Immunization Status—Combination 10* ♦ *Controlling High Blood Pressure—Total* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Kings County	♦ *Adult BMI Assessment—Total* ♦ *Cervical Cancer Screening* ♦ *Childhood Immunization Status—Combination 10* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total*

Managed Care Health Plan	Reporting Unit	Measures
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Madera County	♦ *Adult BMI Assessment—Total* ♦ *Cervical Cancer Screening* ♦ *Controlling High Blood Pressure—Total* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Region 1	♦ *Adult BMI Assessment—Total* ♦ *Cervical Cancer Screening* ♦ *Childhood Immunization Status—Combination 10* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Controlling High Blood Pressure—Total* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total*
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Region 2	♦ *Adult BMI Assessment—Total* ♦ *Cervical Cancer Screening* ♦ *Childhood Immunization Status—Combination 10* ♦ *Controlling High Blood Pressure—Total* ♦ *Prenatal and Postpartum Care—Postpartum Care* ♦ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total*

Managed Care Health Plan	Reporting Unit	Measures
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Sacramento County	♦ *Adult BMI Assessment—Total* ♦ *Childhood Immunization Status—Combination 10* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Controlling High Blood Pressure—Total* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total*
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	San Benito County	♦ *Adult BMI Assessment—Total* ♦ *Cervical Cancer Screening* ♦ *Childhood Immunization Status—Combination 10* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Controlling High Blood Pressure—Total* ♦ *Prenatal and Postpartum Care—Postpartum Care* ♦ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total*

Managed Care Health Plan	Reporting Unit	Measures
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	San Francisco County	♦ *Adult BMI Assessment—Total* ♦ *Cervical Cancer Screening* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Controlling High Blood Pressure—Total* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Prenatal and Postpartum Care—Postpartum Care* ♦ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total*
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Santa Clara County	♦ *Adult BMI Assessment—Total* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Controlling High Blood Pressure—Total* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Managed Care Health Plan	Reporting Unit	Measures
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	Tulare County	♦ *Adult BMI Assessment—Total* ♦ *Cervical Cancer Screening* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Controlling High Blood Pressure—Total* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total*
Blue Shield of California Promise Health Plan	San Diego County	♦ *Adolescent Well-Care Visits* ♦ *Cervical Cancer Screening* ♦ *Childhood Immunization Status—Combination 10* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
California Health & Wellness Plan	Imperial County	♦ *Controlling High Blood Pressure—Total*
California Health & Wellness Plan	Region 1	♦ *Cervical Cancer Screening* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Controlling High Blood Pressure—Total*

Managed Care Health Plan	Reporting Unit	Measures
California Health & Wellness Plan	Region 2	♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total*
CalOptima	Orange County	♦ *Adult BMI Assessment—Total* ♦ *Childhood Immunization Status—Combination 10* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total*
CalViva Health	Fresno County	♦ *Immunizations for Adolescents—Combination 2*
CalViva Health	Kings County	♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
CalViva Health	Madera County	♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
CenCal Health	San Luis Obispo County	♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Controlling High Blood Pressure—Total* ♦ *Immunizations for Adolescents—Combination 2*
CenCal Health	Santa Barbara County	♦ *Cervical Cancer Screening* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total*

Managed Care Health Plan	Reporting Unit	Measures
Central California Alliance for Health	Merced County	♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total*
Central California Alliance for Health	Monterey/Santa Cruz Counties	♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Community Health Group Partnership Plan	San Diego County	♦ *Adult BMI Assessment—Total* ♦ *Childhood Immunization Status—Combination 10* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Controlling High Blood Pressure—Total*
Contra Costa Health Plan	Contra Costa County	♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total*
Gold Coast Health Plan	Ventura County	♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Controlling High Blood Pressure—Total*

Managed Care Health Plan	Reporting Unit	Measures
Health Net Community Solutions, Inc.	Kern County	♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Controlling High Blood Pressure—Total* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Health Net Community Solutions, Inc.	Los Angeles County	♦ *Cervical Cancer Screening* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Health Net Community Solutions, Inc.	Sacramento County	♦ *Controlling High Blood Pressure—Total*
Health Net Community Solutions, Inc.	San Diego County	♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Health Net Community Solutions, Inc.	Stanislaus County	♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Controlling High Blood Pressure—Total* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Health Net Community Solutions, Inc.	Tulare County	♦ *Cervical Cancer Screening* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total*

Managed Care Health Plan	Reporting Unit	Measures
Health Plan of San Joaquin	San Joaquin County	♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Health Plan of San Joaquin	Stanislaus County	♦ *Controlling High Blood Pressure—Total*
Health Plan of San Mateo	San Mateo County	♦ *Cervical Cancer Screening* ♦ *Controlling High Blood Pressure—Total*
Inland Empire Health Plan	Riverside/San Bernardino Counties	♦ *Childhood Immunization Status—Combination 10* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Molina Healthcare of California	Imperial County	♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* ♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total*
Molina Healthcare of California	Riverside/San Bernardino Counties	♦ *Adult BMI Assessment—Total* ♦ *Cervical Cancer Screening* ♦ *Childhood Immunization Status—Combination 10* ♦ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total*

Managed Care Health Plan	Reporting Unit	Measures
		♦ *Comprehensive Diabetes Care—HbA1c Testing—Total* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Molina Healthcare of California	Sacramento County	♦ *Adult BMI Assessment—Total* ♦ *Childhood Immunization Status—Combination 10*
Molina Healthcare of California	San Diego County	♦ *Controlling High Blood Pressure—Total* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Santa Clara Family Health Plan	Santa Clara County	♦ *Cervical Cancer Screening*
San Francisco Health Plan	San Francisco County	♦ *Cervical Cancer Screening* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
UnitedHealthcare Community Plan	San Diego County	♦ *Controlling High Blood Pressure—Total* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Table 2—Reporting Year 2020 Hybrid Measures Reported Using Measurement Year 2019 Administrative Data Only

Note: Both Kaiser NorCal and Kaiser SoCal use KP Health Connect, an electronic health record system, which allows providers to enter service information directly into the system, resulting in a higher degree of data capture and completeness. As a result, both MCPs report all Managed Care Accountability Set (MCAS) measures using the administrative method.

Managed Care Health Plan	Reporting Unit	Measures
Community Health Group Partnership Plan	San Diego County	♦ *Prenatal and Postpartum Care—Postpartum Care* ♦ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* ♦ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Molina Healthcare of California	Sacramento County	♦ *Adolescent Well-Care Visits*
Molina Healthcare of California	San Diego County	♦ *Childhood Immunization Status—Combination 10*