Volume 2 of 5
Medi-Cal Managed Care External Quality Review Technical Report

July 1, 2021–June 30, 2022

Medi-Cal Managed Care Plan-Specific Information

Quality Population Health Management
California Department of Health Care Services

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Table of Contents

Volume 2: Medi-Cal Managed Care Plan-Specific Information

Medi-Cal Managed Care Plan Name Abbreviations v

Commonly Used Abbreviations and Acronyms vi

Appendix A. Comparative MCMC Plan-Specific Compliance Review Results A-1
Follow-Up on Previously Reported Audits A-5

Appendix B. PSP-Specific Performance Measure Results B-1

Appendix C. Comparative MCMC Plan-Specific Performance Improvement Project Information C-1
Module Validation Criteria C-1
Confidence Level Definitions C-3
Performance Improvement Project Topics, Module Progression, and Interventions C-4

Appendix D. Comparative MCMC Plan-Specific Population Needs Assessment Information D-1
Population Needs Assessment Report Submissions D-1
2021 Population Needs Assessment Objectives D-2
2022 Population Needs Assessment Objectives D-19

Appendix E. MCMC Plan-Specific External Quality Review Assessments and Recommendations E-1
Aetna Better Health of California E-1
AIDS Healthcare Foundation E-6
Alameda Alliance for Health E-8
Anthem Blue Cross Partnership Plan E-15
Blue Shield of California Promise Health Plan E-22
California Health & Wellness Plan E-29
CalOptima E-33
CalViva Health E-39
CenCal Health E-52
Central California Alliance for Health E-57
Community Health Group Partnership Plan E-62
Contra Costa Health Plan E-66
Family Mosaic Project E-74
Gold Coast Health Plan E-75
Health Net Community Solutions, Inc. E-93
Health Plan of San Joaquin E-98
Health Plan of San Mateo E-105
Inland Empire Health Plan E-110
Kaiser NorCal E-116
Kaiser SoCal E-122

Kern Family Health Care E-130
L.A. Care Health Plan E-135
Molina Healthcare of California E-142
Partnership HealthPlan of California E-155
San Francisco Health Plan E-162
Santa Clara Family Health Plan E-172
SCAN Health Plan E-177
UnitedHealthcare Community Plan E-182

Table of Tables

Table A.1—Medi-Cal Managed Care Plan 2021–22 A&I Medical and State Supported Services Audits Results and Status A-1
Table B.1—Measurement Years 2019, 2020, and 2021 Performance Measure Results AHF—Los Angeles County B-2
Table B.2—Measurement Years 2019, 2020, and 2021 Performance Measure Results SCAN—Los Angeles/Riverside/San Bernardino Counties B-4
Table C.1—Medi-Cal Managed Care Health Plan 2020–22 Performance Improvement Project Topics and Module Progression C-4
Table C.2—Managed Care Health Plans 2020–22 Health Equity Performance Improvement Project Interventions C-8
Table C.3—Managed Care Health Plans 2020–22 Child and Adolescent Health Performance Improvement Project Interventions C-13
Table C.4—Population-Specific Plans and Specialty Health Plan 2020–22 Performance Improvement Project Interventions C-17
Table D.1—Medi-Cal Managed Care Plan 2021–22 Population Needs Assessment Submissions D-1
Table D.2—Medi-Cal Managed Care Plan 2021 Population Needs Assessment Action Plan Objectives D-3
Table D.3—Medi-Cal Managed Care Plan 2022 Population Needs Assessment Action Plan Objectives D-20
Table E.1—Aetna's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-1
Table E.2—AHF's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-6
Table E.3—AAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-8

Table E.4—Anthem Blue Cross' Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-15
Table E.5—Blue Shield Promise's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-22
Table E.6—CHW's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-29
Table E.7—CalOptima's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-33
Table E.8—CalViva's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-39
Table E.9—CenCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-52
Table E.10—CCAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-57
Table E.11—CHG's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-62
Table E.12—CCHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-66
Table E.13—GCHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-75
Table E.14—Health Net's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-93
Table E.15—HPSJ's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-98
Table E.16—HPSM's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-105
Table E.17—IEHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-110

Table E.18—Kaiser NorCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-116
Table E.19—Kaiser SoCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-122
Table E.20—KHS' Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-130
Table E.21—L.A. Care's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-135
Table E.22—Molina's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-142
Table E.23—Partnership's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-155
Table E.24—SFHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-162
Table E.25—SCFHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-172
Table E.26—SCAN's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-177
Table E.27—UHC's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report E-182

Medi-Cal Managed Care Plan Name Abbreviations

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

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

Commonly Used Abbreviations and Acronyms

- **A&I**—Audits & Investigations Division
- **ADHD**—Attention-Deficit/Hyperactivity Disorder
- **APL**—All Plan Letter
- **BHI**—behavioral health integration
- **BMI**—body mass index
- **CAHPS®**—Consumer Assessment of Healthcare Providers and Systems[1]
- **CalAIM**—California Advancing and Innovating Medi-Cal
- **CAP**—corrective action plan
- **CDSMP**—Chronic Disease Self-Management Program
- **CMS**—Centers for Medicare & Medicaid Services
- **COPD**—chronic obstructive pulmonary disease
- **COVID-19**—coronavirus disease 2019
- **CPT**—Current Procedural Terminology
- **DBA**—doing business as
- **DHCS**—California Department of Health Care Services
- **DMHC**—Department of Managed Health Care
- **ECM**—Enhanced Care Management
- **EHR**—electronic health record
- **EOC**—evidence of coverage
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **FAQ**—frequently asked questions
- **FMEA**—failure modes and effects analysis
- **FQHC**—federally qualified health center
- **GAD**—Grievances and Appeals Department
- **HbA1c**—Hemoglobin A1c
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[2]
- **HIV**—human immunodeficiency virus
- **HMO**—health maintenance organization
- **HPV**—human papillomavirus
- **HSAG**—Health Services Advisory Group, Inc.
- **IHA**—initial health assessment

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- **IHEBA**—Individual Health Education Behavior Assessment
- **IPA**—independent physician association
- **IVR**—interactive voice response
- **LARC**—Long-Acting Reversible Contraception
- **LEP**—limited English proficient
- **MCAS**—Managed Care Accountability Set
- **MCMC**—Medi-Cal Managed Care program
- **MCP**—managed care health plan
- **NCQA**—National Committee for Quality Assurance
- **OB/GYN**—obstetrician/gynecologist
- **P4P**—pay-for-performance
- **PCP**—primary care provider
- **PDSA**—Plan-Do-Study-Act
- **PIP**—performance improvement project
- **PLD**—patient-level detail
- **PNA**—population needs assessment
- **PNF**—Pregnancy Notification Form
- **POM**—provider operations manual
- **PQI**—potential quality issues
- **PSP**—population-specific health plan
- **QIP**—quality improvement plan
- **Roadmap**—HEDIS Record of Administration, Data Management, and Processes
- **STD**—sexually transmitted disease
- **SHP**—specialty health plan
- **SMART**—Specific, Measurable, Achievable, Relevant, and Time-bound
- **SWOT**—Strengths, Weaknesses, Opportunities, Threats
- **VRI**—video remote interpreting

Appendix A. Comparative MCMC Plan-Specific Compliance Review Results

This appendix provides a comparative summary of the compliance reviews the California Department of Health Care Services (DHCS) Audits & Investigations Division (A&I) conducted for MCMC plans. The summary is based on final audit reports issued and corrective action plan (CAP) closeout letters submitted by DHCS to HSAG for production of this 2021–22 external quality review (EQR) technical report, including the MCMC plan-specific results. The summary includes new information not reported in previous review periods. Note that while DHCS did not provide new information for all MCMC plans, DHCS' A&I conducted compliance reviews (i.e., Medical and State Supported Services Audits) for all MCMC plans within the previous three-year period as required by the Code of Federal Regulations at Title 42, Section 438.358.

For the most up-to-date A&I audit reports and related CAP information, go to: http://www.dhcs.ca.gov/services/Pages/MedRevAuditsCAP.aspx.

Table A.1 presents the results and status of MCMC plans' A&I Medical and State Supported Services Audits.

Table A.1—Medi-Cal Managed Care Plan 2021–22 A&I Medical and State Supported Services Audits Results and Status

C1: Category 1—Utilization Management

C2: Category 2—Case Management and Coordination of Care

C3: Category 3—Access and Availability of Care

C4: Category 4—Member's Rights

C5: Category 5—Quality Management

C6: Category 6—Administrative and Organizational Capacity

C7: Category 7—State Supported Services

No Findings: DHCS identified no findings related to the category during the audits.

New Findings: DHCS identified new findings related to the category and imposed a CAP.

Repeat Findings: DHCS identified findings similar to those in the previous audit and imposed a CAP.

CAP in Process: The CAP is still in process and under review.

CAP Closed: All findings have been rectified.

N/A: DHCS did not assess this category during the audit.

Medi-Cal Managed Care Plan Name	Audit Year	C1	C2	C3	C4	C5	C6	C7
AAH	2022	New and Repeat Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	No Findings	New and Repeat Findings (CAP in Process)	No Findings
Aetna	2021	New Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	No Findings
Aetna	2022	New Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	Repeat Findings (CAP in Process)	No Findings	New Findings (CAP in Process)	New Findings (CAP in Process)
AHF	2022	New Findings (CAP Closed)	New Findings (CAP Closed)	New and Repeat Findings (CAP Closed)	New Findings (CAP Closed)	New Findings (CAP Closed)	New Findings (CAP Closed)	No Findings
Anthem Blue Cross	2021	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	No Findings	No Findings	New Findings (CAP in Process)	No Findings
Blue Shield Promise	2022	New and Repeat Findings (CAP in Process)	New Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	Repeat Findings (CAP in Process)	No Findings	No Findings
CalOptima	2022	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	No Findings	No Findings
CalViva	2022	No Findings	New Findings (CAP in Process)	New Findings (CAP in Process)	No Findings	No Findings	No Findings	No Findings

Medi-Cal Managed Care Plan Name	Audit Year	C1	C2	C3	C4	C5	C6	C7
CCHP	2021	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	Repeat Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	No Findings	New Findings (CAP in Process)
CenCal	2021	No Findings	New Findings (CAP Closed)	New Findings (CAP Closed)	New Findings (CAP Closed)	New Findings (CAP Closed)	New Findings (CAP Closed)	No Findings
CHG	2021	No Findings	New Findings (CAP Closed)	New and Repeat Findings (CAP Closed)	No Findings	New Findings (CAP Closed)	No Findings	New Findings (CAP Closed)
CHW	2021	No Findings	No Findings	New and Repeat Findings (CAP Closed)	No Findings	No Findings	N/A	No Findings
GCHP	2021	No Findings	No Findings	No Findings	New Findings (CAP Closed)	No Findings	N/A	No Findings
Health Net	2022	New Findings (CAP in Process)	New Findings (CAP in Process	New and Repeat Findings (CAP in Process)	Repeat Findings (CAP in Process)	No Findings	No Findings	No Findings
HPSJ	2021	New Findings (CAP in Process)	New Findings (CAP in Process)	No Findings	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	No Findings
HPSM	2021	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	New Findings (CAP in Process)	No Findings

Medi-Cal Managed Care Plan Name	Audit Year	C1	C2	C3	C4	C5	C6	C7
IEHP	2021	New Findings (CAP Closed)	No Findings	New Findings (CAP Closed)	New Findings (CAP Closed)	New Findings (CAP Closed)	No Findings	No Findings
Kaiser NorCal	2021	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	No Findings	New Findings (CAP in Process)	No Findings
Kaiser SoCal	2021	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	Repeat Findings (CAP in Process)	New Findings (CAP in Process)	No Findings
KHS	2021	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	No Findings
L.A. Care	2021	New and Repeat Findings (CAP in Process)	New Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	New Findings (CAP in Process)	No Findings	New Findings (CAP in Process)	N/A
Partnership	2021	No Findings	No Findings	No Findings	No Findings	No Findings	N/A	No Findings
RCHSD	2021	No Findings	No Findings	No Findings	No Findings	No Findings	N/A	No Findings
SCAN	2022	New Findings (CAP in Process)	N/A	New Findings (CAP in Process)	No Findings	No Findings	No Findings	N/A
SCFHP	2022	New Findings (CAP in Process)	New Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	New Findings (CAP in Process)	No Findings

Medi-Cal Managed Care Plan Name	Audit Year	C1	C2	C3	C4	C5	C6	C7
SFHP	2022	New and Repeat Findings (CAP in Process)	New and Repeat Findings (CAP in Process)	No Findings	New and Repeat Findings (CAP in Process)	New Findings (CAP in Process)	No Findings	No Findings
UHC	2021	New Findings (CAP Closed)	No Findings	New Findings (CAP Closed)	New Findings (CAP Closed)	Repeat Findings (CAP Closed)	New Findings (CAP Closed)	No Findings

Follow-Up on Previously Reported Audits

While HSAG provided a results summary for the following Medical and State Supported Services Audits in previous EQR technical reports, the CAPs from the audits were in process and under DHCS review at the time of reporting. The following provides status updates of the CAPs at the production of this report:

- AAH—2019 and 2021 Medical and State Supported Services Audit CAPs still in process
- AHF—2021 Medical Audit CAP still in process
- Blue Shield Promise—2021 Medical Audit CAP closed
- CalViva—2020 Medical Audit CAP closed
- CCHP—2020 Medical Audit CAP still in process (implementation of 2020 Medical Audit CAP reviewed during 2021 Medical and State Supported Services Audits)
- Health Net—2021 Medical Audit CAP still in process
- SCAN—2021 Medical Audit CAP closed
- SCFHP—2020 and 2021 Medical Audit CAPs still in process
- SFHP—2021 Medical Audit CAP still in process (implementation of 2021 Medical Audit CAP reviewed during 2022 Medical and State Supported Services Audits)

Appendix B. PSP-Specific Performance Measure Results

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

Table B.1 and Table B.2 provide performance measure results for measurement years 2019, 2020, and 2021 for AHF and SCAN, respectively.

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

- To allow HSAG to provide a meaningful assessment of PSP performance and actionable recommendations, HSAG, in collaboration with DHCS, organized the measures into domains based on the health care areas each measure affects.
- High performance levels and minimum performance levels represent the 2021 National Committee for Quality Assurance (NCQA) Quality Compass®,[3] Medicaid health maintenance organization (HMO) 90th and 50th percentiles, respectively.
  - As described in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*, due to the coronavirus disease 2019 (COVID-19) public health emergency, DHCS decided not to compare measurement year 2019 performance measure results to benchmarks; therefore, HSAG does not display comparison of measurement year 2019 rates to the high performance levels and minimum performance levels in these tables.
- For the *Controlling High Blood Pressure—Total* measure:
  - HSAG only displays the measurement years 2020 and 2021 rates due to NCQA recommending a break in trending from measurement year 2019 to measurement year 2020.
  - Based on DHCS' performance measure requirements, HSAG compares the rates for this measure to the high performance level and minimum performance level for measurement year 2021 only.
- HSAG only compares high performance levels and minimum performance levels for the following measures because for all other measures either no national benchmarks existed or DHCS did not hold the PSP accountable to meet the minimum performance levels:
  - *Breast Cancer Screening—Total* (SCAN only)
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)—Total* (both AHF and SCAN)

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

- *Screening for Depression and Follow-Up Plan—Ages 65+ Years* (SCAN only)

Please refer to Table 6.1 and Table 6.2 in Section 6 of *Volume 1 of 5* of this report ("Managed Care Health Plan Performance Measures") for the descriptions of all performance measures and the benchmarks HSAG used for high performance level and minimum performance level comparisons included in the applicable tables.

Table B.1—Measurement Years 2019, 2020, and 2021 Performance Measure Results AHF—Los Angeles County

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

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

= Statistical testing result indicates that the measurement year 2021 rate is significantly better than the measurement year 2020 rate.

= Statistical testing result indicates that the measurement year 2021 rate is significantly worse than the measurement year 2020 rate.

Measurement year 2019 rates reflect data from January 1, 2019, through December 31, 2019.

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

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

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

— Indicates that the rate is not available.

* 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 to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard. If a measurement year 2020 or measurement year 2021 rate is suppressed, HSAG also suppresses the measurement year 2020–21 rate difference. Note that while the rate difference is suppressed, a performance comparison is conducted, and instances of statistically significant differences are denoted as indicated previously.

Not Comparable = A measurement year 2020–21 rate difference cannot be calculated because data are not available for both years or because significant methodology changes occurred between years, disallowing comparison.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
Women's Health Domain				
Contraceptive Care—All Women—Long-Acting Reversible Contraception (LARC)—Ages 21–44 Years	NA	NA	NA	Not Comparable
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years	NA	NA	NA	Not Comparable
Behavioral Health Domain				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	—	—	NA	Not Comparable
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	—	—	NA	Not Comparable
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	—	—	NA	Not Comparable
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	—	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan—Ages 18–64 Years	0.00%	51.23%	50.75%	-0.48%
Screening for Depression and Follow-Up Plan—Ages 65+ Years	NA	NA	NA	Not Comparable

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
Acute and Chronic Disease Management Domain				
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total**	S	22.00%	26.15%	4.15
*Concurrent Use of Opioids and Benzodiazepines—Ages 18–64 Years**	26.23%	31.37%	27.69%	-3.68
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years**	NA	NA	NA	Not Comparable
Controlling High Blood Pressure—Total	—	69.70%	63.56%	-6.14
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 18–64 Years**	S	S	20.00%	S
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years**	NA	NA	NA	Not Comparable

Table B.2—Measurement Years 2019, 2020, and 2021 Performance Measure Results SCAN—Los Angeles/Riverside/San Bernardino Counties

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

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

= Statistical testing result indicates that the measurement year 2021 rate is significantly better than the measurement year 2020 rate.

= Statistical testing result indicates that the measurement year 2021 rate is significantly worse than the measurement year 2020 rate.

Measurement year 2019 rates reflect data from January 1, 2019, through December 31, 2019.

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

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

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

* A lower rate indicates better performance for this measure.

— Indicates that the rate is not available.

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

Not Comparable = A measurement year 2020–21 rate difference cannot be calculated because data are not available for both years.

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
Women's Health Domain				
Breast Cancer Screening—Total	84.48%	77.35%	77.09%	-0.26
Behavioral Health Domain				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence— 7-Day Follow-Up—Total	—	—	NA	Not Comparable
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence— 30-Day Follow-Up—Total	—	—	NA	Not Comparable
Follow-Up After Emergency Department Visit for Mental Illness— 7-Day Follow-Up—Total	—	—	NA	Not Comparable
Follow-Up After Emergency Department Visit for Mental Illness— 30-Day Follow-Up—Total	—	—	NA	Not Comparable
Screening for Depression and Follow-Up Plan— Ages 65+ Years	17.81%	25.75%	33.58%	7.83

Measure	Measurement Year 2019 Rate	Measurement Year 2020 Rate	Measurement Year 2021 Rate	Measurement Years 2020–21 Rate Difference
Acute and Chronic Disease Management Domain				
*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total**	14.11%	20.55%	17.53%	-3.02
*Concurrent Use of Opioids and Benzodiazepines—Ages 65+ Years**	13.27%	13.45%	12.09%	-1.36
Controlling High Blood Pressure—Total	—	66.42%	68.46%	2.04
*Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+ Years**	1.94%	1.65%	1.58%	-0.07

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

This appendix provides the module validation criteria and confidence level definitions for HSAG's rapid-cycle performance improvement project (PIP) process. Additionally, this appendix includes MCMC plan-specific PIP topics and module progression information, as well as descriptions of interventions MCMC plans tested during the review period of July 1, 2021, through June 30, 2022.

Module Validation Criteria

HSAG conducts PIP validation in accordance with the Centers for Medicare & Medicaid Services (CMS) *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019.[4] Following are the validation criteria that HSAG uses for each module:

Module 1—PIP Initiation

- The MCMC plan provided the description and rationale for the selected narrowed focus, and the reported baseline data support an opportunity for improvement.
- The narrowed focus baseline specifications and data collection methodology supported the rapid-cycle process and included the following:
  - Complete and accurate specifications.
  - Data source(s).
  - Step-by-step data collection process.
  - Narrowed focus baseline data that considered claims data completeness.
- The SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) Aim was stated accurately and included all required components (i.e., narrowed focus, intervention[s], baseline percentage, goal percentage, and end date).
- The SMART Aim run chart included all required components (i.e., run chart title, Y-axis title, SMART Aim goal percentage line, narrowed focus baseline percentage line, and X-axis months).
- The MCMC plan completed the attestation and confirmed the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.

[4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Sep 22, 2022.

- The MCMC plan accurately completed all required components of the key driver diagram. The drivers and interventions were logically linked and have the potential to impact the SMART Aim goal.

Module 2—Intervention Determination

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

Module 3—Intervention Testing

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

Module 4—PIP Conclusions

- The rolling 12-month data collection methodology was followed for the SMART Aim measure for the duration of the PIP.
- The MCMC plan provided evidence to demonstrate at least one of the following:
  - The SMART Aim goal was achieved.
  - Statistically significant improvement over the narrowed focus baseline percentage was achieved (95 percent confidence level, $p < 0.05$).
  - Non-statistically significant improvement in the SMART Aim measure.
  - Significant clinical improvement in processes and outcomes.
  - Significant programmatic improvement in processes and outcomes.

- If improvement was demonstrated, at least one of the tested interventions could reasonably result in the demonstrated improvement.
- The MCMC plan completed the Plan-Do-Study-Act (PDSA) worksheet(s) with accurately reported data and interpretation of testing results.
- The narrative summary of the project conclusions was complete and accurate.
- If improvement was demonstrated, the MCMC plan documented plans for sustaining improvement beyond the SMART Aim end date.

Confidence Level Definitions

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

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

improvement; however, none of the tested interventions could reasonably result in the demonstrated improvement.

- No confidence
  - The SMART Aim measure and/or approved rapid-cycle PIP methodology was not followed through the SMART Aim end date.

Performance Improvement Project Topics, Module Progression, and Interventions

As of the end of the review period of the *2021–22 Medi-Cal Managed Care External Quality Review Technical Report*, all MCMC plans met modules 1 through 3 validation criteria and progressed to the intervention testing phase for both their 2020–22 PIPs.

Performance Improvement Project Topics and Module Progression

Table C.1 lists MCMC plans' PIP topics and shows module progression at the end of the review period.

Table C.1—Medi-Cal Managed Care Health Plan
2020–22 Performance Improvement Project Topics and Module Progression

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

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

Met = The MCMC plan met all required validation criteria for the module.

In Process = The MCMC plan is in the process of completing the module.

N/A = The MCMC plan will not be required to submit the module due to its contract with DHCS ending.

MCMC Plan Name	PIP Topic	Module 1	Module 2	Module 3	Module 4
Managed Care Health Plans					
AAH	*Breast Cancer Screening Among African Americans* (Health Equity PIP)	Met	Met	Met	In Process
	Child and Adolescent Well-Care Visits (Ages 3 to 21)	Met	Met	Met	In Process

MCMC Plan Name	PIP Topic	Module 1	Module 2	Module 3	Module 4
Aetna*	*Diabetes Control*	Met	Met	Met	In Process
	Well-Child Visits (Ages 3 to 11)	Met	Met	Met	In Process
Anthem Blue Cross	*Cervical Cancer Screening Among Vietnamese Members* (Health Equity PIP)	Met	Met	Met	In Process
	Childhood Immunizations	Met	Met	Met	In Process
Blue Shield Promise	*Childhood Immunizations Among Non-Hispanic Members* (Health Equity PIP)	Met	Met	Met	In Process
	Well-Child Visits in the First 30 Months of Life	Met	Met	Met	In Process
CalOptima	*Breast Cancer Screening Among Chinese and Korean Members* (Health Equity PIP)	Met	Met	Met	In Process
	Well-Child Visits in the First 15 Months of Life	Met	Met	Met	In Process
CalViva	*Breast Cancer Screening Among Hmong-Speaking Members* (Health Equity PIP)	Met	Met	Met	In Process
	Childhood Immunizations	Met	Met	Met	In Process
CCAH	*Child and Adolescent Well-Care Visits Among Members Residing in Merced County* (Health Equity PIP)	Met	Met	Met	In Process
	Childhood Immunizations	Met	Met	Met	In Process
CCHP	*Diabetes Control Among Members Residing in Specific Regions of Contra Costa County* (Health Equity PIP)	Met	Met	Met	In Process
	Well-Child Visits (Ages 3 to 6)	Met	Met	Met	In Process
CenCal	*Postpartum Care for Members Residing in San Luis Obispo County* (Health Equity PIP)	Met	Met	Met	In Process
	Well-Child Visits in the First 15 Months of Life	Met	Met	Met	In Process

MCMC Plan Name	PIP Topic	Module 1	Module 2	Module 3	Module 4
CHG	*Adolescent Well-Care Visits (Ages 12 to 17)*	Met	Met	Met	In Process
	Cervical Cancer Screening Among Black/African-American Members (Health Equity PIP)	Met	Met	Met	In Process
CHW	*Breast Cancer Screening Among Members Living with Disabilities in Region 1* (Health Equity PIP)	Met	Met	Met	In Process
	Childhood Immunizations	Met	Met	Met	In Process
GCHP	*Adolescent Well-Care Visits (Ages 12 to 17)*	Met	Met	Met	In Process
	Cervical Cancer Screening Among Members Residing in Area 5 (Health Equity PIP)	Met	Met	Met	In Process
Health Net	*Breast Cancer Screening Among Russian Members in Sacramento County* (Health Equity PIP)	Met	Met	Met	In Process
	Childhood Immunizations	Met	Met	Met	In Process
HPSJ	*Adolescent Well-Care Visits (Ages 18 to 21)*	Met	Met	Met	In Process
	Cervical Cancer Screening Among White Members Residing in Stanislaus County (Health Equity PIP)	Met	Met	Met	In Process
HPSM	*Adolescent Well-Care Visits (Ages 18 to 21)*	Met	Met	Met	In Process
	Breast Cancer Screening Among African-American Members (Health Equity PIP)	Met	Met	Met	In Process
IEHP	*Adolescent Well-Care Visits (Ages 18 to 21)*	Met	Met	Met	In Process
	Controlling High Blood Pressure Among African-American Members (Health Equity PIP)	Met	Met	Met	In Process

MCMC Plan Name	PIP Topic	Module 1	Module 2	Module 3	Module 4
Kaiser NorCal	*Childhood Immunizations*	Met	Met	Met	In Process
	Hypertension Control Among African-American Members Living in South Sacramento (Health Equity PIP)	Met	Met	Met	In Process
Kaiser SoCal	*Adolescent Well-Care Visits (Ages 12 to 21)*	Met	Met	Met	In Process
	Well-Child Visits Among Members 7 to 11 Years of Age (Health Equity PIP)	Met	Met	Met	In Process
KHS	*Asthma Medication Ratio*	Met	Met	Met	In Process
	Well-Child Visits Among Members Living in Central Bakersfield (Health Equity PIP)	Met	Met	Met	In Process
L.A. Care	*Childhood Immunizations*	Met	Met	Met	In Process
	Diabetes Among African-American Members (Health Equity PIP)	Met	Met	Met	In Process
Molina	*Childhood Immunizations*	Met	Met	Met	In Process
	Diabetes Control Among African-American Members Residing in Sacramento County (Health Equity PIP)	Met	Met	Met	In Process
Partnership	*Breast Cancer Screening Among Members Living in Rural and Small Counties* (Health Equity PIP)	Met	Met	Met	In Process
	Well-Child Visits in the First 15 Months of Life	Met	Met	Met	In Process
SCFHP	*Adolescent Well-Care Visits in Network 20* (Health Equity PIP)	Met	Met	Met	In Process
	Lead Screening in Children	Met	Met	Met	In Process
SFHP	*Breast Cancer Screening Among African-American Members* (Health Equity PIP)	Met	Met	Met	In Process
	Well-Child Visits in the First 15 Months of Life	Met	Met	Met	In Process

MCMC Plan Name	PIP Topic	Module 1	Module 2	Module 3	Module 4
UHC*	*Cervical Cancer Screening*	Met	Met	Met	N/A
	Child and Adolescent Well-Care Visits (Ages 3 to 21)	Met	Met	Met	N/A
Population-Specific Health Plans					
AHF*,^	*Controlling High Blood Pressure*	Met	Met	Met	N/A
	Human Immunodeficiency Virus (HIV) Viral Load Suppression	Met	Met	Met	N/A
RCHSD*	*Blood Lead Test*	Met	Met	Met	N/A
	Diabetes Control	Met	Met	Met	N/A
SCAN^	*Breast Cancer Screening*	Met	Met	Met	In Process
	Diabetes Control Among Spanish-Speaking Members (Health Equity PIP)	Met	Met	Met	In Process
Specialty Health Plan					
FMP*	*Improving Family Functioning*	Met	Met	Met	N/A
	Reducing Anxiety Symptoms	Met	Met	Met	N/A

Performance Improvement Project Interventions

Table C.2 through Table C.4 list PIP topics and descriptions of interventions that HSAG approved MCMC plans to test for the 2020–22 PIPs. If the MCMC plan determined to abandon an approved intervention during the review period, HSAG notes this in the tables.

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

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

MCP Name	PIP Topic	Interventions
Breast Cancer Screening		
AAH	*Breast Cancer Screening Among African Americans*	Educate members on the importance of regular screenings and provide a list of imaging centers where they can have their mammograms completed. *(Abandoned)*

MCP Name	PIP Topic	Interventions
		Provide member incentives on completion of the mammogram.
CalOptima	*Breast Cancer Screening Among Chinese and Korean Members*	Obtain monthly data identifying members assigned to the PIP provider partner who are due for breast cancer screenings and share the list with the PIP provider partner to use for outreach. *(Abandoned)*
		Implement a mobile mammography community event for eligible CalOptima members in partnership with the PIP provider partner and a mobile mammography vendor.
CalViva	*Breast Cancer Screening Among Hmong-Speaking Members*	Conduct a Hmong Sisters health educational event.
		Conduct a member-friendly mobile mammography event.
CHW	*Breast Cancer Screening Among Members Living with Disabilities in Region 1*	Provide care coordination for members with disabilities to improve access to and completion of their breast cancer screenings.
Health Net	*Breast Cancer Screening Among Russian Members in Sacramento County*	Provide care coordination for breast cancer screenings through participating provider groups or imaging centers.
HPSM	*Breast Cancer Screening Among African-American Members*	Outreach to African-American members who are due for breast cancer screenings.
Partnership	*Breast Cancer Screening Among Members Living in Rural and Small Counties*	Develop and implement training for the PIP health center partner staff members on breast cancer screening internal processes that include member outreach and screening mammography order procedures.
SFHP	*Breast Cancer Screening Among African-American Members*	Provide patient navigation services for African-American members.

MCP Name	PIP Topic	Interventions
Cervical Cancer Screening		
Anthem Blue Cross	*Cervical Cancer Screening Among Vietnamese Members*	Conduct virtual educational sessions with four low-performing primary care providers (PCPs), incorporating principles of cultural sensitivity and health literacy around well-woman care, with the goal of improving cervical cancer screening rates among their Vietnamese-American members ages 24 to 30 years.
		Conduct virtual group educational sessions for members, incorporating health literacy materials and resources in English and Vietnamese, and offer a member incentive for completing the sessions.
CHG	*Cervical Cancer Screening Among Black/African-American Members*	Conduct an outreach campaign to schedule appointments and assess and mitigate barriers to appointment completion (e.g., set up transportation when making the appointment).
GCHP	*Cervical Cancer Screening Among Members Residing in Area 5*	Implement a multi-component outreach campaign that includes text messaging to encourage female members ages 24 to 29 years and enrolled at the PIP medical center partner to schedule and complete a cervical cancer screening by December 31, 2022. *(Abandoned)*
HPSJ	*Cervical Cancer Screening Among White Members Residing in Stanislaus County*	Conduct targeted focus groups and surveys to identify the greatest needs (e.g., access, education) for members ages 24 to 64 years who reside in Stanislaus County, are in need of cervical cancer screening, and are assigned to the PIP clinic partner. Incorporate identified needs to a scripted outreach call by the population health team.
UHC*	*Cervical Cancer Screening*	Incorporate the *Patient Care Opportunity Report* into quality improvement activities with select practices.

MCP Name	PIP Topic	Interventions
Controlling High Blood Pressure		
IEHP	*Controlling High Blood Pressure Among African-American Members*	Conduct a targeted medication review to identify members diagnosed with hypertension who are not prescribed 90-day supplies, and use fax forms to encourage the members' providers to prescribe 90-day supplies.
		Conduct targeted medication reviews to identify members diagnosed with hypertension and type 2 diabetes who are not prescribed 90-day supplies, and make outreach calls to encourage members to obtain prescriptions for 90-day supplies.
Kaiser NorCal	*Hypertension Control Among African-American Members Living in South Sacramento*	Train providers who already have a relationship with the patient population to order blood pressure monitors and provide educational resources to improve controlled hypertension.
		Collect blood pressure readings taken at home via QR code that link to a secure Microsoft form. *(Abandoned)*
		Auto-order home blood pressure machines and enroll members in health education classes.
Diabetes Control		
Aetna*	*Diabetes Control*	Implement a 12-week, home-delivered, medically tailored meals pilot program called Mom's Meals. *(Abandoned)*
CCHP	*Diabetes Control Among Members Residing in Specific Regions of Contra Costa County*	Implement a cellular-enabled smart blood glucose meter coupled with one-on-one care management delivered by the MCP's registered nurse or certified diabetes care and education specialist.
L.A. Care	*Diabetes Control Among African-American Members*	Conduct phone outreach to African-American members assigned to the PIP health center partner who have a missing HbA1c result or an HbA1c level greater than 9 percent, to provide information on

MCP Name	PIP Topic	Interventions
		medication instructions, medication efficacy, healthy lifestyle suggestions, and general resources for scheduling appointments and picking up medications.
Molina	*Diabetes Control Among African-American Members Residing in Sacramento County*	Mail an HbA1c testing kit to eligible members to complete the test at their homes.
Child and Adolescent Health		
Blue Shield Promise	*Childhood Immunizations Among Non-Hispanic Members*	Fund a health navigator who can outreach to non-Hispanic members to address immunization concerns, provide immunization scheduling assistance, and provide member education support.
CCAH	*Child and Adolescent Well-Care Visits Among Members Residing in Merced County*	Increase the number of in-person well-care visit appointment slots per week.
Kaiser SoCal	*Well-Child Visits Among Members 7 to 11 Years of Age*	Send birthday postcard reminders for well-care visits for members 7 to 11 years of age.
KHS	*Well-Child Visits Among Members Living in Central Bakersfield*	Implement a member engagement and rewards program that provides bilingual robocall, text, and mailer messaging with rewards for completing an annual well-child visit.
		As staffing permits, conduct Saturday clinics to complete annual well-child visits.
SCFHP	*Adolescent Well-Care Visits in Network 20*	Provide incentive rewards to members who complete their adolescent well-care visits.
Women's Health		
CenCal	*Postpartum Care for Members Residing in San Luis Obispo County*	Coordinate making postpartum visit appointments for women assigned to the PIP provider partner.

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

MCP Name	PIP Topic	Interventions
Childhood Immunizations		
Anthem Blue Cross	*Childhood Immunizations*	Host flu shot clinic day events at two high-volume pediatric PCP sites, targeting Black children who are in the denominator for the *Childhood Immunization Status—Combination 10* measure; offer member incentives to complete scheduled flu immunizations and provide immunization health education/resources.
		Conduct virtual group educational sessions for parents/guardians, incorporating culturally relevant health literacy materials and resources, and offer a member incentive for completing the session.
CalViva	*Childhood Immunizations*	Have the PIP provider partner conduct reminders/text campaign.
		Implement recurring Heroes for Health immunization events.
CCAH	*Childhood Immunizations*	Work with the local immunization registry, Regional Immunization Data Exchange, to correct data exchange issues.
CHW	*Childhood Immunizations*	Have community health workers provide education to members during pregnancy about the importance of infant vaccines and staying on the infant vaccine schedule.
Health Net	*Childhood Immunizations*	Make workflow changes to patient office visits to include identification and administration of needed vaccines, outreach, and scheduling vaccine visits.
Kaiser NorCal	*Childhood Immunizations*	Conduct outreach to parents/guardians of members who missed their well-child visits. Encouraging well-child visit compliance will also increase childhood immunization administration. *(Abandoned)*
		Conduct pre-appointment outreach calls to decrease missed well-child visit appointments.

MCP Name	PIP Topic	Interventions
		Encouraging well-child visit compliance will also increase childhood immunization administration.
L.A. Care	*Childhood Immunizations*	Use customized missing vaccine reports for outreach calls.
Molina	*Childhood Immunizations*	Reconcile undisclosed records on the California Immunization Registry 2 data with the PIP clinic partners for their eligible members under 2 years of age.
Well-Care Visits		
AAH	*Child and Adolescent Well-Care Visits (Ages 3 to 21)*	Send birthday mailers to parents/guardians of eligible members to receive a $25 gift card incentive at the end of a well-child visit.
Aetna	*Well-Child Visits (Ages 3 to 11)*	Add a flag in the electronic health record (EHR) system to alert member-facing staff members of open well-child visit care gaps.
Blue Shield Promise	*Well-Child Visits in the First 30 Months of Life*	Provide funding for the federally qualified health center (FQHC) to hire a health navigator to assist with making outreach calls and scheduling appointments for members.
CalOptima	*Well-Child Visits in the First 15 Months of Life*	Establish data sharing procedures between the MCP and the PIP provider partner office to identify members due for outreach.
CCHP	*Well-Child Visits (Ages 3 to 6)*	Outreach to parents/guardians of African-American members ages 3 to 6 years and schedule well-child visit appointments at the point of outreach.
CenCal	*Well-Child Visits in the First 15 Months of Life*	Help coordinate well-child visits for pediatric members' parents/guardians.
CHG	*Adolescent Well-Care Visits (Ages 12 to 17)*	To gain agreements from the members' parents/guardians to schedule appointments, conduct member outreach calls to educate parents/guardians on what a well-child visit is, its importance, and how it differs from a sports physical or sick visit.

MCP Name	PIP Topic	Interventions
GCHP	*Adolescent Well-Care Visits (Ages 12 to 17)*	To engage adolescents ages 12 to 17 years who are enrolled at the PIP clinic partner to schedule their well-care exams, implement a bundled outreach program that includes phoning members to promote the well-care exam member incentive program.
HPSJ	*Adolescent Well-Care Visits (Ages 18 to 21)*	Conduct targeted outreach via collaboration with providers to get members in for well-care visits.
HPSM	*Adolescent Well-Care Visits (Ages 18 to 21)*	Give a $25 gift card to members ages 18 to 21 years when they complete their teen well-care visits at the PIP clinic partner.
IEHP	*Adolescent Well-Care Visits (Ages 18 to 21)*	Review future scheduled appointments for members ages 18 to 21 years and allocate sufficient time during the upcoming visit to incorporate the well-care visit components.
Kaiser SoCal	*Adolescent Well-Care Visits (Ages 12 to 21)*	Send birthday postcards to members ages 12 to 17 years with a reminder to complete their well-care visits.
Partnership	*Well-Child Visits in the First 15 Months of Life*	Create and coordinate Saturday clinics specifically for well-child appointments for the 0- to 15-month-old population.
SFHP	*Well-Child Visits in the First 15 Months of Life*	Conduct targeted outreach to parents/guardians of members who are due for a well-child visit, which includes an offer of a financial incentive for members who attend the recommended number of well-child visits as well as education on the importance of up-to-date preventive care services for children.
UHC	*Child and Adolescent Well-Care Visits (Ages 3 to 21)*	Offer a gift card at the point of care at select practices.
Other Child and Adolescent Health Topics		
KHS	*Asthma Medication Ratio*	Request medical records from PCPs to review and use while filling out asthma action plans, educating parents/guardians of members about medications and their asthma conditions.
		As needed during meetings with members, help members and their parents/guardians fill out,

MCP Name	PIP Topic	Interventions
		review, and update their asthma action plans, and encourage members to take the asthma action plans to their PCP to review during visits.
		Change the disease management member outreach process to include making three attempts to reach parents/guardians of members on different days and times. If they are not reached, contact members' PCPs for alternative contact information. If they cannot be reached via phone, mail a letter.
SCFHP	*Lead Screening in Children*	Conduct provider training about care gaps, the importance of blood lead screening, and placing orders for members.

Table C.4—Population-Specific Plans and Specialty Health Plan 2020–22 Performance Improvement Project Interventions

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

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

PSP/SHP Name	PIP Topic	Interventions
AHF*,^	*Controlling High Blood Pressure*	Provide transportation to all members to and from appointments.
		Provide member education on blood pressure monitor use and how to properly record blood pressure.
		Distribute home blood pressure monitors to all members with hypertension.
		Inform staff members about strategies to improve the *Controlling High Blood Pressure* measure rate (treatment plans, multiple readings, body placement, and member comfortability).
	Human Immunodeficiency Virus (HIV) Viral Load Suppression	Provide transportation to appointments.
		Provide member education in multiple languages about the importance of regular testing and test frequency.
		Conduct provider outreach with information on frequency of testing recommendations.
		Encourage members to participate in the PSP's partnering services (e.g., Mom's Meals, Healthy Housing).
		Provide appointment reminders for members with a scheduled lab appointment and coordinate transportation as needed.

PSP/SHP Name	PIP Topic	Interventions
FMP*	*Improving Family Functioning*	Obtain information from families about ways in which they may not feel welcomed, supported, or respected by FMP clinicians and staff. The concerns will be acknowledged and addressed quickly, and timely feedback (monthly) will be provided to families about the changes that have been made to address their concerns.
	Reducing Anxiety Symptoms	Provide training to FMP clinicians on anxiety treatment best practices.
RCHSD*	*Blood Lead Test*	Have the PIP provider partner outreach to members needing blood lead screening.
	Diabetes Control	Schedule child life appointments based on provider referrals.
SCAN^	*Breast Cancer Screening*	Provide gaps-in-care reports to the PIP medical group partners to ensure they incentivize providers for timely claims submissions.
	Diabetes Control Among Spanish-Speaking Members (Health Equity PIP)	Implement processes to confirm member engagement and completion of the case management/disease management diabetes program for self-management/diabetes education.

Note that during HSAG's production of this EQR technical report, DHCS notified HSAG of the following DHCS contractual changes:

- The RCHSD contract ended December 31, 2021.
- FMP is to no longer be included in EQR activities as of May 2022.
- The UHC contract will end on December 31, 2022.

RCHSD and UHC submitted a PIP close-out report for each PIP conducted. The PIP close-out report included the PIP SMART Aim run chart, SMART Aim measure monthly data, and intervention testing progress through the end of their contracts with DHCS. Based on DHCS' contractual changes, HSAG includes the final information regarding these MCMC plans' PIPs in this EQR technical report.

Appendix D. Comparative MCMC Plan-Specific Population Needs Assessment Information

This appendix provides MCMC plans' 2021–22 population needs assessment (PNA) report submissions as well as the 2021 and 2022 PNA objectives, including the progress made on the 2021 objectives. Note that due to the size and type of population that FMP serves, DHCS does not require the SHP to conduct a PNA.

Population Needs Assessment Report Submissions

Table D.1 provides the number of PNA report submissions required before DHCS provided approval, the MCMC plan's final PNA report submission date, and the date DHCS approved the PNA report.

Table D.1—Medi-Cal Managed Care Plan 2021–22 Population Needs Assessment Submissions

MCMC Plan Name	Number of Submissions Required	Final Submission Date	DHCS Approval Date
AAH	2	7/11/22	7/12/22
Aetna	1	7/15/22	8/22/22
AHF	1	8/01/22	8/30/22
Anthem Blue Cross	1	6/27/22	7/05/22
Blue Shield Promise	1	7/28/22	8/08/22
CalOptima	2	6/30/22	7/07/22
CalViva	1	6/30/22	7/12/22
CCAH	1	6/29/22	7/08/22
CCHP	2	7/20/22	8/04/22
CenCal	1	6/27/22	7/05/22
CHG	1	6/30/22	7/20/22
CHW	2	7/25/22	7/26/22
GCHP	1	6/30/22	7/25/22
Health Net	3	8/15/22	8/26/22
HPSJ	1	6/30/22	7/18/22

MCMC Plan Name	Number of Submissions Required	Final Submission Date	DHCS Approval Date
HPSM	1	7/29/22	9/14/22
IEHP	2	7/13/22	7/15/22
Kaiser NorCal	1	6/30/22	7/19/22
Kaiser SoCal	2	7/29/22	8/04/22
KHS	1	6/21/22	7/01/22
L.A. Care	1	5/31/22	6/15/22
Molina	1	7/07/22	8/01/22
Partnership	1	4/01/22	6/29/22
SCAN	3	7/20/22	8/02/22
SCFHP	2	7/13/22	7/15/22
SFHP	1	6/30/22	9/01/22
UHC	1	6/23/22	6/30/22

2021 Population Needs Assessment Objectives

Table D.2 provides the following:

- High-level summaries of the MCMC plans' 2021 PNA Action Plan objectives
- Whether the objectives address a health disparity
- Whether the progress made on each objective is better, worse, none, or unknown
- The status of each objective:
  - Continuing into 2022
  - Changing for 2022
  - Ended in 2021

Table D.2—Medi-Cal Managed Care Plan 2021 Population Needs Assessment Action Plan Objectives

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
AAH	By December 31, 2021, increase annual participation of Hispanic (Latino) and Black (African-American) children ages 0 to 18 years in the Asthma Start in-home case management program.	No	Worse	Ended in 2021
	By December 31, 2022, achieve the measurement year 2020 minimum performance level for the *Asthma Medication Ratio—Total* measure for Black (African-American) adults ages 19 to 64 years.	Yes	Better	Ended in 2021
	By December 31, 2022, improve the Consumer Assessment of Healthcare Providers and Systems (CAHPS) rate for getting a check-up or routine care appointment as soon as needed to pre-COVID 2019 rates for adults and children.	No	Unknown	Ended in 2021
	By December 31, 2022, increase the *Child and Adolescent Well-Care Visits—Total* measure rate for two identified providers.	No	Unknown	Ended in 2021
	By December 31, 2022, improve the *Breast Cancer Screening—Total* measure rate among Black (African-American) women ages 52 to 74 years.	Yes	None	Continuing into 2022
Aetna	By May 31, 2022, decrease the prevalence of hypertension among African-American and Asian members in Sacramento and San Diego counties.	Yes	Worse	Continuing into 2022
	By May 2022, decrease the percentage of members with an opioid substance use disorder.	No	Unknown	Continuing into 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	By December 2021, improve the *Rating of Health Plan* CAHPS 2021 scores for both adult and child populations.	No	Unknown	Ended in 2021
AHF	By July 1, 2022, increase HIV viral load suppression among members.	No	Better	Continuing into 2022
	By July 1, 2022, increase retinal eye exam screenings among members diagnosed with diabetes.	No	Better	Continuing into 2022
	By July 1, 2022, increase the percentage of members who perceive to have good communication with their doctors.	No	Worse	Continuing into 2022
	By July 1, 2022, increase the percentage of members with controlled blood pressure.	No	Worse	Continuing into 2022
	By July 1, 2022, increase the percentage of members who perceive to be getting needed care from the PSP.	No	Better	Continuing into 2022
	By July 1, 2022, increase the percentage of correct documented email addresses in the business intelligence portal.	No	Worse	Continuing into 2022
	By July 1, 2022, increase HIV viral load suppression among Hispanic/Latinx members.	Yes	Worse	Continuing into 2022
Anthem Blue Cross	Improve the rates for both *Prenatal and Postpartum Care* measures for members participating in the doula pilot cohort.	No	Better	Changing for 2022
	Maintain a monthly average utilization rate of 700 visits for video interpretation during 2021.	No	Worse	Changing for 2022
	In 2021, maintain a targeted range of total rate of successful case management member engagement	No	Worse	Ended in 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	for counties with an available community health worker.			
	By December 2022, improve the *Childhood Immunization Status—Combination 10* measure rate among Black/African-American children residing in Sacramento County.	Yes	Better	Changing for 2022
Blue Shield Promise	By June 30, 2022, increase the percentage of members who report that their doctor always communicates well.	No	Better	Continuing into 2022
	By June 30, 2022, increase the percentage of members who receive timely prenatal care in the first trimester of their pregnancy at the pilot clinic.	No	Better	Ended in 2021
	By June 30, 2022, increase the percentage of members who receive an annual flu vaccine.	No	Better	Continuing into 2022
	By June 30, 2022, increase the percentage of Black/African-American and Hispanic/Latino members who receive timely prenatal care in the first trimester.	Yes	Better	Ended in 2021
CalOptima	By December 31, 2023, improve the rates for the member experience measures (i.e., *Getting Needed Care* and *Getting Care Quickly*).	No	Better	Continuing into 2022
	By December 31, 2023, increase HbA1c testing and diabetes retinal eye exams.	No	Worse	Continuing into 2022
	By December 31, 2023, improve the rates for the *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* measures.	No	Better	Continuing into 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	By December 31, 2023, improve the *Lead Screening in Children* measure rate.	No	Worse	Continuing into 2022
	By December 31, 2022, achieve a targeted rate for COVID-19 vaccine adherence for eligible members.	No	Unknown	Continuing into 2022
	By December 31, 2023, improve the *Breast Cancer Screening—Total* measure rate for Chinese and Korean members.	Yes	Better	Continuing into 2022
CalViva	By June 30, 2022, the Health Education Department will continue increasing annual utilization of the myStrength Program.	No	Better	Continuing into 2022
	By December 31, 2022, increase the breast cancer screening rate among Hmong-, Laotian-, and Khmer-speaking females ages 50 to 74 years assigned to the targeted clinic in Fresno County.	Yes	Worse	Continuing into 2022
	By June 30, 2022, the Cultural and Linguistics Services Department will increase the use of new video remote interpreting (VRI) services to support member language needs.	No	Better	Continuing into 2022
CCAH	By December 31, 2022, increase the percentage of members in all three counties who report in CAHPS that they were “usually” or “always” able to get care quickly.	No	Worse	Continuing into 2022
	By December 31, 2022, increase staff and provider utilization of telephonic interpreting calls and provider utilization of on-site face-to-face interpreting during medical visits in all three counties for members with	No	Better	Changing for 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	limited English proficiency or who are deaf and/or hard of hearing.			
	By December 31, 2021, at least half of Healthier Living Program participants will have reported their ability to manage their chronic health condition(s) as either good, very good, or excellent.	No	Better	Ended in 2021
	By June 30, 2023, increase the percentage of members who attend their well-child visits in the first 30 months of life and receive their recommended childhood immunizations by age 2 in Merced County.	Yes	Better	Changing for 2022
CCHP	Decrease the percentage of obese members with an HbA1c level greater than 9.0 who reside in specific regions of Contra Costa County.	Yes	Better	Continuing into 2022
	By December 2022, increase the percentage of 3- to 6- year-old African-American members assigned to a select provider who attend an annual well-child visit.	Yes	Better	Continuing into 2022
	In 2022, improve the percentage of members screened for depression and follow-up.	No	Unknown	Ended in 2021
	By 2022, increase the number of providers who talk to members regarding ways to prevent illnesses.	No	Unknown	Ended in 2021
	By 2022, reduce emergency room visits for anxiety.	No	Unknown	Ended in 2021
	By 2022, increase providers' knowledge about how to access interpreter services and increase the provider access survey rating.	No	Better	Ended in 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	By 2022, decrease the number of members who are not aware of the Advice Nurse Line and increase access to the Advice Nurse Line.	No	Unknown	Ended in 2021
	By 2022, increase the percentage of health education services and materials that meet members' needs.	No	Better	Ended in 2021
CenCal	By June 1, 2022, increase diabetic and pre-diabetic members' use of nutrition education services (e.g., registered dietician or certified diabetes educator).	No	Better	Ended in 2021
	By June 1, 2022, increase the breast cancer screening rate for English-speaking members in both counties.	Yes	Worse	Continuing into 2022
	By January 1, 2023, increase the childhood developmental screening rate for children age 1 in San Luis Obispo County.	Yes	Better	Continuing into 2022
CHG	By July 1, 2023, increase the proportion of adult members who get needed care quickly.	No	Better	Ended in 2021
	By July 1, 2023, increase the proportion of child members who get needed care with a specialist.	No	Better	Continuing into 2022
	By July 1, 2023, increase the proportion of adult members who get needed care with a specialist.	No	Better	Continuing into 2022
	By July 1, 2023, increase the proportion of members with good or excellent overall physical health.	No	Worse	Continuing into 2022
	By July 1, 2023, increase the *Cervical Cancer Screening* measure rate for the White racial/ethnic group.	Yes	Worse	Continuing into 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	By July 1, 2023, increase the *Cervical Cancer Screening* measure rate for the Asian racial/ethnic group.	Yes	Worse	Continuing into 2022
	By July 1, 2023, increase the *Cervical Cancer Screening* measure rate for the Black racial/ethnic group.	Yes	Better	Continuing into 2022
	By July 1, 2023, increase the *Breast Cancer Screening—Total* measure rate for the White racial/ethnic group.	Yes	Worse	Continuing into 2022
	By July 1, 2023, increase the *Breast Cancer Screening—Total* measure rate for the American Indian/Alaska Native racial/ethnic group.	Yes	Worse	Continuing into 2022
	By July 1, 2023, increase the *Breast Cancer Screening—Total* measure rate for the Black racial/ethnic group.	Yes	Worse	Continuing into 2022
	By July 1, 2023, increase the *Breast Cancer Screening—Total* measure rate for the Native Hawaiian/Other Pacific Islander racial/ethnic group.	Yes	Worse	Continuing into 2022
	By July 1, 2023, reduce the *Plan All-Cause Readmissions* measure rate for the White racial/ethnic group.	Yes	Worse	Continuing into 2022
	By July 1, 2023, reduce the *Plan All-Cause Readmissions* measure rate for the American Indian/Alaska Native racial/ethnic group.	Yes	Worse	Continuing into 2022
	By July 1, 2023, reduce the *Plan All-Cause Readmissions* measure rate for the Black racial/ethnic group.	Yes	Worse	Continuing into 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
CHW	By June 30, 2022, the Health Education Department will continue increasing annual utilization of the myStrength program.	No	Better	Continuing into 2022
	By June 30, 2022, the Cultural and Linguistics Services Department will increase utilization of VRI services to support member language needs.	No	Better	Continuing into 2022
	By December 31, 2022, increase the percentage of breast cancer screenings among women ages 50 to 64 years in Region 1 who have a Medi-Cal aid code that indicates a disability and who are assigned to the targeted participating physician groups.	Yes	Worse	Continuing into 2022
GCHP	By December 31, 2021, increase the percentage of members 5 to 64 years of age with a diagnosis of persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	No	Better	Ended in 2021
	By December 31, 2021, increase the rate for the *Chlamydia Screening in Women—Total* measure to meet or exceed the DHCS minimum performance level.	No	Better	Continuing into 2022
	By December 31, 2021, increase the percentage of cervical cancer screenings among women 21 to 64 years of age.	No	Worse	Ended in 2021
	By December 31, 2021, increase the percentage of breast cancer screenings among women 50 to 74 years of age.	No	Worse	Continuing into 2022
	By December 31, 2021, implement a hypertension education program for	No	Worse	Continuing into 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	members with hypertension to increase the percentage of members 18 to 85 years of age with controlled blood pressure (<140/90 mm Hg).			
	By December 31, 2021, implement a diabetes education program for GCHP Hispanic members with diabetes living in the Oxnard, Port Hueneme, Santa Paula, and Fillmore areas and decrease the percentage of members diagnosed with poor HbA1c control (>9.0 percent).	Yes	Worse	Continuing into 2022
	Implement a provider cultural competency training and increase awareness among providers.	No	Better	Ended in 2021
	By December 31, 2020, implement an awareness campaign of language access services among providers and members to increase the percentage of providers able to address health literacy for shared decision making and improve communication with members.	No	Unknown	Ended in 2021
Health Net	By June 30, 2022, the Health Education Department will increase annual utilization of the myStrength program.	No	Better	Continuing into 2022
	By June 30, 2022, the Cultural and Linguistics Services Department will increase utilization of VRI services to support member language needs.	No	Better	Ended in 2021
	By December 31, 2022, increase the percentage of breast cancer screenings among members 50 to 74 years of age identified as Russian by race/ethnicity and/or language and assigned to Sacramento County.	Yes	Worse	Changing for 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
HPSJ	By June 30, 2023, increase overall utilization of language assistance by members, providers, and internal staff.	No	Better	Continuing into 2022
	By June 30, 2022, improve engagement from members and community partners by increasing the number of new members in the Community Advisory Committee by 10 in areas not currently represented either ethnically, linguistically, or geographically.	No	Better	Ended in 2021
	By June 30, 2022, implement a virtual diabetes prevention program with a vendor and have at least one complete cohort of members.	No	None	Ended in 2021
	By December 31, 2022, increase the cervical cancer screening compliance rate among White/Caucasian women ages 24 to 64 years residing in Stanislaus County who were assigned to the clinic partner.	Yes	Better	Continuing into 2022
HPSM	By December 31, 2022, improve the *Customer Service* CAHPS adult measure rate to above all other health plans' top box scores.	No	Unknown	Ended in 2021
	By December 31, 2022, improve the *Customer Service* CAHPS pediatric measure rate.	No	Unknown	Ended in 2021
	By December 31, 2022, improve the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate to above the Healthcare Effectiveness Data and Information Set (HEDIS) 2020 90th percentile.	No	Better	Continuing into 2022
	By December 31, 2022, improve the *Prenatal and Postpartum Care—Postpartum Care* measure rate to	No	Better	Continuing into 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	above the HEDIS 2020 90th percentile and keep the rate at this level or higher.			
	By December 31, 2022, see a decrease in the number of teen pregnancies for members between the ages of 15 and 19.	No	None	Ended in 2021
	By December 20, 2022, increase compliance for the *Cervical Cancer Screening* measure for the Korean-speaking language group to equal to or greater than the average group rate.	Yes	Worse	Continuing into 2022
	By December 31, 2022, increase the *Breast Cancer Screening—Total* measure rate for the Black subgroup to greater than or equal to the average group rate.	Yes	Better	Ended in 2021
	By December 31, 2022, increase the percentage of provider requests for Spanish-speaking phone or video interpreters.	Yes	Better	Ended in 2021
IEHP	By July 1, 2022, aim for overall improvement in the *Controlling High Blood Pressure–Total* measure and reduce the percentage point difference (disparity) between the reference group of members who identify as Hispanic and members who identify as Black.	Yes	Better	Continuing into 2022
	By July 1, 2022, improve *Asthma Medication Ratio* measure rates among members in the San Bernardino proper region to reduce the percentage point difference between this region and the reference rate.	Yes	Worse	Continuing into 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	By July 1, 2022, improve the *Statin Therapy for People with Diabetes* measure rate.	No	Better	Continuing into 2022
	By July 1, 2022, improve the depression screening rate across all age groups.	No	Better	Continuing into 2022
	By July 1, 2022, improve the *Developmental Screening in the First Three Years of Life—Total* measure rate among IEHP members ages 0 to 3 years who prefer English.	Yes	Unknown	Ended in 2021
	By July 1, 2022, improve the rate at which providers advise members about smoking or tobacco cessation.	No	Worse	Ended in 2021
Kaiser NorCal	Increase kp.org member portal activation for members 13 years of age and older from Quarter 1 2020 to Quarter 4 2022.	No	Better	Ended in 2021
	By December 31, 2022, increase controlled hypertension among African-American members ages 18 to 65 in South Sacramento.	Yes	Better	Ended in 2021
	Decrease tobacco prevalence among members with a PCP in the North Valley service area from Quarter 1 2020 to Quarter 1 2022.	No	Better	Ended in 2021
Kaiser SoCal	By December 31, 2022, decrease the disparity in the well-care visit rate among members ages 7 to 11 compared to members ages 3 to 6.	Yes	Better	Ended in 2021
	By December 31, 2022, increase the percentage of members ages 12 to 21 who have completed an adolescent well-care visit.	No	Better	Ended in 2021
	From Quarter 1 2021 to Quarter 4 2022, decrease the prevalence of tobacco users among members.	No	Better	Continuing into 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
KHS	By June 2023, increase the initial health assessment (IHA) completion rate.	No	Worse	Continuing into 2022
	By June 2023, increase the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure rate.	No	Better	Changing for 2022
	By June 2023, increase the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure rate.	No	Worse	Continuing into 2022
	By June 2023, increase the *Child and Adolescent Well-Care Visits—Total* measure rate.	No	Worse	Continuing into 2022
	By June 2023, increase the average class participation rate in the asthma education class series.	No	Better	Changing for 2022
	By June 2024, increase the percentage of Black pediatric members who complete at least six well-child visits by 15 months of age.	Yes	Better	Changing for 2022
	By June 2024, increase the percentage of Black pediatric members who complete at least two well-child visits between 15 and 30 months of age.	Yes	Worse	Continuing into 2022
L.A. Care	By December 31, 2022, decrease the percentage of members reporting consumption of less than one daily serving of fruits and vegetables.	No	Worse	Ended in 2021
	By December 31, 2022, increase the percentage of members reporting that their doctor spoke with them about eating healthy foods.	No	Better	Ended in 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	By December 31, 2022, decrease the percentage of African-American/Black members between the ages of 18 and 75 diagnosed with diabetes who were assigned to the community health center partner and have an HbA1c level greater than 9.0 percent.	Yes	None	Continuing into 2022
Molina	By December 31, 2022, increase the percentage of eligible members residing in Sacramento County with a specified clinic as their PCP who have completed all recommended childhood immunizations before their second birthday.	No	Worse	Continuing into 2022
	By December 31, 2022, increase the percentage of African-American members residing in Sacramento County identified as having diabetes with HbA1C levels less than 8.0 percent.	Yes	Worse	Continuing into 2022
	By December 31, 2021, increase the percentage of members 0 to 15 months of age who have documented completion of the recommended number of well-child visits.	No	Better	Continuing into 2022
	By June 30, 2022, increase the percentage of members identified as having a diagnosis of prediabetes who participate in the Diabetes Prevention Program.	No	Better	Continuing into 2022
	By December 31, 2022, increase access to face-to-face interpretation, including VRI, for limited English proficient (LEP) members in Molina's counties of operation.	No	Better	Continuing into 2022
	By December 31, 2022, increase the percentage of independent practice	No	Better	Continuing into 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	association providers rating their satisfaction with the availability of an appropriate range of interpreters as "Very Good" or "Excellent."			
Partnership	By March 1, 2022, increase the proportion of non-English-speaking/non-White members reporting grievances.	No	Better	Changing for 2022
	By December 31, 2021, promote members' use of VRI services at provider sites.	No	Better	Ended in 2021
	By December 31, 2021, provide two trainings to address health equity knowledge gaps for internal staff members.	No	Better	Changing for 2022
	By March 1, 2022, increase the *Breast Cancer Screening—Total* measure rate among American Indians/Alaska Native members.	Yes	Worse	Changing for 2022
	By March 1, 2022, improve the *Asthma Medication Ratio—Total* measure rate for pediatric members in the Northeast and Northwest regions.	Yes	Worse	Changing for 2022
	By December 30, 2021, improve the well-child visit rates for Hispanic/Latino members ages 3 to 5 years in the Northeast and Northwest regions.	No	Better	Ended in 2021
SCAN	By December 31, 2022, increase the percentage of Spanish-speaking members with controlled diabetes.	Yes	Worse	Continuing into 2022
	By March 31, 2022, increase the number of members assisted with accessing care and/or closing gaps in care.	No	None	Changing for 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	By March 31, 2022, increase the portion of the population who use online health education.	No	Better	Ended in 2021
	By March 31, 2022, reduce the performance gap of medication adherence measures for Black and Spanish-speaking members.	Yes	Better	Ended in 2021
	By March 31, 2022, increase the percentage of Spanish-speaking members who receive the annual flu vaccine.	Yes	Worse	Ended in 2021
	By March 31, 2022, reduce the COVID-19 vaccination disparity among Black and Spanish-speaking members.	Yes	Better	Ended in 2021
SCFHP	By December 31, 2022, increase the *Controlling High Blood Pressure—Total* measure rate for the Black population.	Yes	Better	Continuing into 2022
	By December 31, 2022, increase the *Cervical Cancer Screening* measure rates for Asian Indian and Filipino members ages 21 to 64 years.	Yes	Worse	Ended in 2021
	By December 31, 2022, increase the well-visit rate for members ages 3 to 21 years.	No	Better	Ended in 2021
	By December 31, 2023, improve the percentage of "Always" and "Usually" responses for the adult CAHPS *Getting Needed Care* measure.	No	Worse	Continuing into 2022
SFHP	By June 2022, improve the *Breast Cancer Screening—Total* measure rate for Black/African-American members.	Yes	Better	Continuing into 2022
UHC	Deliver culturally appropriate member campaigns to reach a larger percentage of the member population	Yes	None	Continuing into 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Progress	Status
	(whose preferred language is not English), increasing the total number of HEDIS measures with rates meeting the minimum performance levels from eight measures in measurement year 2020 to 10 measures in measurement year 2021.			
	By December 31, 2022, increase the *Prenatal and Postpartum Care—Postpartum Care* measure rate by supporting food security for postpartum care for the maternal health population using Mom's Meals.	Yes	Unknown	Changing for 2022
	By December 31, 2022, increase the *Controlling High Blood Pressure—Total* measure rate by implementing a more integrated population health management approach to our members.	No	Unknown	Continuing into 2022

2022 Population Needs Assessment Objectives

Table D.3 provides the following:

- High-level summaries of the MCMC plans' 2022 PNA Action Plan objectives
- Whether the objectives address a health disparity
- The status of each objective:
  - New in 2022
  - Continued from 2021
  - Changed from 2021

Table D.3—Medi-Cal Managed Care Plan 2022 Population Needs Assessment Action Plan Objectives

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
AAH	From measurement year 2021 to measurement year 2023, increase the *Controlling High Blood Pressure* measure rate for members ages 18 to 85 years with a diagnosis of hypertension who are assigned to a provider group delegate.	No	New in 2022
	From 2021 to 2023, increase the number of members ages 19 years and older with diabetes who engage with AAH health education and disease management programs regarding diabetes self-management.	No	New in 2022
	From measurement year 2021 to measurement year 2022, increase the rates for both *Well-Child Visits in the First 30 Months of Life* measures.	No	New in 2022
	From measurement year 2021 to measurement year 2022, improve the *Breast Cancer Screening—Total* measure rate among Black (African-American) women ages 52 to 74 years.	Yes	Continued from 2021
Aetna	By September 2022, reduce or eliminate disparities for Black (African-American) and Hispanic members by improving the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure rate.	Yes	Changed from 2021
	For the measurement year 2022 CAHPS surveys to be conducted in July 2023, improve member satisfaction related to the CAHPS questions that ask whether the adult or child member's personal doctors explained things in a way that was easy to understand.	Yes	New in 2022
	By October 2022, achieve or exceed the national Medicaid 50th percentile for the *Pharmacotherapy for Opioid Use Disorder* measure rate.	No	Changed from 2021
	For measurement year 2021, increase the *Prenatal and Postpartum Care—Postpartum*	No	New in 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
	Care measure rate for Black (African-American) members and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate for Filipino members.		
	By October 2022, achieve or exceed the national Medicaid 50th percentile for the *Child and Adolescent Well-Care Visits—Total* measure rate.	No	New in 2022
AHF	By July 1, 2022, increase HIV viral load suppression among members.	No	Continued from 2021
	By July 1, 2022, increase retinal eye exam screenings among members diagnosed with diabetes.	No	Continued from 2021
	By July 1, 2022, increase the percentage of members who perceive to have good communication with their doctors.	No	Continued from 2021
	By July 1, 2022, increase the percentage of members with controlled blood pressure.	No	Continued from 2021
	By July 1, 2022, increase the percentage of members who perceive to be getting needed care from the PSP.	No	Continued from 2021
	By July 1, 2022, increase the percentage of documented and correct member email addresses in the PSP's member management system.	No	Continued from 2021
	By July 1, 2022, increase HIV viral load suppression among Hispanic/Latinx members.	Yes	Continued from 2021
Anthem Blue Cross	In measurement year 2022, increase the total members enrolled in the Medicaid Doula Program.	Yes	Changed from 2021
	By June 30, 2023, deploy 14 Digital Solutions kiosks (mobile iPads) for on-demand interpretation services and telehealth services in four counties to reduce language barriers and improve health equity.	No	Changed from 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
	By June 30, 2023, expand the delivery of community supports pertaining to food and housing in all service areas for members with high or special health care needs.	No	New in 2022
	In measurement year 2022, improve the *Childhood Immunization Status—Combination 10* measure rate among Black/African-American children residing in Sacramento and Fresno counties.	Yes	Changed from 2021
Blue Shield Promise	By June 30, 2024, increase the percentage of members who report that their doctor always communicates well.	No	Continued from 2021
	By June 30, 2024, increase the percentage of Black/African-American members with controlled blood pressure.	Yes	New in 2022
	By June 30, 2024, increase the percentage of members who receive an annual flu vaccine.	No	Changed from 2021
	By June 30, 2024, increase the percentage of members who report getting an interpreter when they need one.	Yes	New in 2022
CalOptima	By December 31, 2023, improve the rates for the member experience measures (i.e., *Getting Needed Care* and *Getting Care Quickly*).	No	Continued from 2021
	By December 31, 2023, increase HbA1c testing and diabetes retinal eye exams.	No	Continued from 2021
	By December 31, 2023, improve the rate for the *Childhood Immunization Status—Combination 10* measure and maintain the current rate for the *Immunizations for Adolescents—Combination 2* measure, which is above the minimum performance level.	No	Continued from 2021
	By December 31, 2023, improve the *Lead Screening in Children* measure rate.	No	Continued from 2021
	By December 31, 2022, achieve a targeted rate for COVID-19 vaccine adherence for eligible members.	No	Continued from 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
	By December 31, 2023, improve the *Breast Cancer Screening—Total* measure rate for Chinese and Korean members.	Yes	Changed from 2021
CalViva	By June 30, 2023, the Health Education Department will continue increasing annual utilization of the myStrength Program.	No	Continued from 2021
	By December 31, 2022, increase the breast cancer screening rate among Hmong-, Laotian-, and Khmer-speaking females ages 60 to 74 years assigned to the targeted clinic in Fresno County.	Yes	Continued from 2021
	By June 30, 2023, the Health Equity Department will continue to increase the use of on-demand VRI services and in-office telephonic interpretation services to support member language needs.	No	Continued from 2021
CCAH	By December 31, 2022, increase the percentage of adult members in all three counties who report in CAHPS that they were “usually” or “always” able to get care quickly.	No	Changed from 2021
	By December 31, 2022, increase the percentage of child members’ parents/guardians in all three counties who report in CAHPS that they were “usually” or “always” able to get care quickly.	No	Changed from 2021
	By June 30, 2023, increase staff and provider utilization of telephonic interpreter calls in all three counties for members with LEP or who are deaf and/or hearing impaired.	No	Changed from 2021
	By June 30, 2023, increase provider utilization of on-site, face-to-face interpreting during medical visits in all three counties for members with LEP or who are deaf and/or hearing impaired.	No	Changed from 2021
	By June 30, 2023, increase the percentage of members who attend their well-child visits in the first 30 months of life in Merced County.	Yes	Continued from 2021
	By June 30, 2023, increase the percentage of members who receive their recommended	Yes	Continued from 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
	childhood immunizations by age 2 in Merced County.		
CCHP	By December 2024, increase antidepressant medication adherence for African-American and Hispanic/Latino members.	Yes	New in 2022
CCHP	By 2024, increase health education resources available to members in the top four requested areas of healthy eating, exercise, healthy teeth, and high blood pressure.	No	New in 2022
CCHP	By 2024, decrease the number of members who are unaware of how to access mental health/behavioral health services, as measured by the member satisfaction survey.	No	New in 2022
CCHP	By December 2022, decrease the percentage of members with obesity and an HbA1c level of >9.0 percent who reside in east and west counties.	Yes	Continued from 2021
CCHP	By December 2022, increase the percentage of 3- to 6-year-old African-American members assigned to a select provider who attend an annual well-child visit.	Yes	Continued from 2021
CenCal	By January 1, 2024, increase the childhood developmental screening rate for children age 1 in San Luis Obispo County.	Yes	Continued from 2021
CenCal	By January 1, 2024, increase the breast cancer screening rate for English-speaking members in both counties.	Yes	Continued from 2021
CenCal	By January 1, 2024, increase the percentage of members who have completed clinically recommended cervical cancer screenings.	No	New in 2022
CenCal	By January 1, 2024, increase the percentage of members with hypertension in Santa Barbara County who have a recorded blood pressure measurement.	Yes	New in 2022
CHG	By July 1, 2023, increase the proportion of adult and child members who get needed care with a specialist.	No	Continued from 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
	By July 1, 2023, increase the proportion of members with good or excellent overall physical health.	No	Continued from 2021
	By July 1, 2023, increase the *Cervical Cancer Screening* measure rates for the White, Asian, and Black racial/ethnic groups.	Yes	Continued from 2021
	By July 1, 2023, increase *Breast Cancer Screening—Total* measure rates for the White, American Indian/Alaska Native, Black, and Native Hawaiian/Other Pacific Islander racial/ethnic groups.	Yes	Continued from 2021
	By July 1, 2023, reduce the *Plan All-Cause Readmissions* measure rates for the White, American Indian/Alaska Native, and Black racial/ethnic groups.	Yes	Continued from 2021
CHW	By June 30, 2023, the Health Education Department will continue increasing annual utilization of the myStrength program.	No	Continued from 2021
	By June 30, 2023, the Health Equity Department will increase the utilization of on-demand VRI services and in-office telephonic interpretation services to support member language needs.	No	Continued from 2021
	By December 31, 2022, increase the percentage of breast cancer screenings among women ages 50to 64 years in Region 1 who have a Medi-Cal aid code that indicates a disability and who are assigned to the targeted participating physician groups.	Yes	Continued from 2021
GCHP	By December 31, 2022, increase the percentage of chlamydia screenings among women 16 to 24 years who were identified as sexually active and/or who had at least one chlamydia screening during the measurement year to meet or exceed the minimum performance rate for the *Chlamydia Screening in Women—Total* measure.	No	Changed from 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
	By December 31, 2022, increase the percentage of breast cancer screenings among women 50 to 74 years of age.	No	Changed from 2021
	By December 31, 2022, increase the percentage of tobacco and alcohol use screenings among adolescents 11 to 17 years of age.	Yes	New in 2022
	By December 31, 2022, increase the percentage of members being seen for their well-child visits in the first 15 months of life.	No	New in 2022
	By December 31, 2022, increase the percentage of children who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	No	New in 2022
	By December 31, 2022, increase the percentage of children 1 to 5 years of age who are at "elevated" risk (i.e., "moderate" or "high") who received at least two topical fluoride applications.	No	New in 2022
	By December 31, 2022, increase the penetration rate among Spanish-speaking members from behavior health program referrals.	Yes	New in 2022
	By December 31, 2022, implement a Chronic Disease Self-Management Program (CDSMP) for GCHP members with chronic conditions (including diabetes, hypertension, anxiety, depression, high cholesterol, lung disease, chronic pain, etc.) to increase the percentage of members who improve their overall health.	Yes	New in 2022
Health Net	By June 30, 2023, the Health Education Department will continue increasing annual utilization of the myStrength program.	No	New in 2022
	By December 31, 2022, increase the percentage of breast cancer screenings among members 50 to 74 years of age identified as Russian by race/ethnicity and/or language and assigned to Sacramento County.	Yes	Changed from 2021
	By June 30, 2023, the Health Equity Department will increase the utilization of on-demand VRI	No	New in 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
	services and in-office telephonic interpretation services to support member language needs.		
	By June 30, 2022, the Health Education Department will continue to increase utilization of the myStrength program.	No	Continued from 2021
HPSJ	By June 30, 2023, increase overall utilization of language assistance by members, providers, and internal staff.	Yes	Continued from 2021
	By December 31, 2024, increase the rate of completed well-child visits to above the national Medicaid 50th percentile for members 0 to 15 months of age, 15 to 30 months of age, and 3 to 21 years of age by implementing children's health milestone initiatives focused on developmental milestones and incentivizing preventive care.	No	Changed from 2021
	By June 30, 2024, increase enrollment and retention in the Diabetes Prevention Program.	No	Continued from 2021
	By December 31, 2022, increase the cervical cancer screening compliance rate among White/Caucasian women ages 24 to 64 years residing in Stanislaus County who were assigned to the clinic partner.	No	Continued from 2021
HPSM	By December 31, 2023, increase the percentage of adolescent well-care visits among young adults and teens assigned to the clinic partner.	No	New in 2022
	By December 31, 2023, improve the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate to above the HEDIS 2021 90th percentile.	No	Continued from 2021
	By December 31, 2023, maintain the *Prenatal and Postpartum Care—Postpartum Care* measure rate above the HEDIS 2021 90th percentile.	No	Continued from 2021
	By December 31, 2023, improve the cervical cancer screening rate for older adults and people with disabilities to equal HPSM's overall *Cervical Cancer Screening* measure rate.	Yes	Continued from 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
	By December 31, 2023, improve the cervical cancer screening rate for Korean-speaking members to equal HPSM's overall *Cervical Cancer Screening* measure rate.	Yes	Continued from 2021
	By December 31, 2023, improve the breast cancer screening rate for Arabic-speaking members to equal HPSM's overall *Breast Cancer Screening—Total* measure rate.	Yes	Continued from 2021
	By December 31, 2023, increase the *Breast Cancer Screening—Total* measure rate for the Black subgroup to greater than or equal to the average group rate.	Yes	Continued from 2021
	By December 31, 2023, improve the *Controlling High Blood Pressure* measure rate to above the 2021 high performance level.	No	Continued from 2021
	By December 31, 2023, decrease the rate for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure for the 17 to 21 years of age subgroup.	No	Continued from 2021
IEHP	By December 31, 2024, improve the overall rate of well-child visits to at least the national Medicaid 50th percentile	No	New in 2022
	By December 31, 2024: ♦ Improve overall asthma medication ratio compliance rates among members qualifying for this measure to the national Medicaid 50th percentile. ♦ For the *Asthma Medication Ratio—Total* measure, reduce the percentage point difference between the disparate region of San Bernardino Proper and IEHP's overall membership.	Yes	Changed from 2021
	By December 31, 2024, improve HEDIS *Comprehensive Diabetes Care* measure compliance to the national Medicaid 90th percentile.	No	Changed from 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
	By December 31, 2024, improve the rate of depression screening and follow-up across all age groups.	No	Changed from 2021
	By December 31, 2024, for IEHP's member population qualifying for the *Controlling High Blood Pressure* measure: ♦ Aim for overall improvement to the national Medicaid 90th percentile. ♦ Reduce the percentage point difference (disparity) between members who identify as Black and IEHP's overall membership.	Yes	Changed from 2021
	By July 1, 2023, improve flu vaccination uptake among adult IEHP members to reach the national Medicaid 90th percentile.	No	New in 2022
Kaiser NorCal	By December 2024, improve the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure rate.	No	New in 2022
	From Quarter 3 2021 to Quarter 3 2024, improve the *Prenatal and Postpartum Care—Postpartum Care* measure rate among African-American members in Sacramento Valley.	Yes	New in 2022
	By December 31, 2024, enroll at least 25 percent of eligible members with a severe mental illness into enhanced care management.	No	New in 2022
Kaiser SoCal	By December 31, 2023, decrease the disparity in the well-child visit rate for children 15 to 30 months of age compared to children in the first 15 months of life by increasing the percentage of children who have completed two well-child visits between 15 and 30 months of age.	Yes	New in 2022
	By December 31, 2023, increase the percentage of children who have completed at least one blood test for lead poisoning by their second birthday.	No	New in 2022
	From Quarter 1 2021 to Quarter 4 2022, decrease the prevalence of tobacco users among	No	Continued from 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
	members in the San Diego service area by providing evidence-based interventions to help members quit tobacco in convenient ways, meeting the varying needs of tobacco users, and implementing an effective service delivery and evaluation/reporting infrastructure.		
KHS	By June 2023, increase the IHA completion rate.	No	Continued from 2021
	By June 2023, increase the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure rate.	No	Continued from 2021
	By June 2023, increase the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure rate.	No	Continued from 2021
	By June 2023, increase the *Child and Adolescent Well-Care Visits—Total* measure rate.	No	Continued from 2021
	By June 2023, increase the average attendance rate of the asthma education class.	No	Continued from 2021
	By June 2024, increase the percentage of Black/African-American pediatric members who complete at least six well-child visits by 15 months of age.	Yes	Continued from 2021
	By June 2024, increase the percentage of Black/African-American pediatric members who complete at least two well-child visits between 15 and 30 months of age.	Yes	Continued from 2021
	By June 2025, increase the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate.	No	Continued from 2021
L.A. Care	By June 30, 2023, decrease the percentage of members who report using tobacco (cigarettes, pipe/cigar, or chewing tobacco).	No	New in 2022
	By June 30, 2023, decrease the percentage of Black/African-American members between the ages of 18 and 75 who were assigned to the	Yes	Continued from 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
	community health center partner and have an HbA1c level greater than 9.0 percent.		
Molina	By December 31, 2022, increase the percentage of eligible members residing in Sacramento County with a specified clinic as their PCP who have completed all recommended childhood immunizations before their second birthday.	No	Continued from 2021
	By December 31, 2022, increase the percentage of African-American members residing in Sacramento County identified as having diabetes with HbA1C levels less than 8.0 percent.	Yes	Continued from 2021
	By December 31, 2023, increase the percentage of members 0 to 15 months of age who have documented completion of the recommended number of well-child visits.	No	Continued from 2021
	By December 31, 2023, increase the percentage of members identified as having a diagnosis of prediabetes who participate in the Diabetes Prevention Program.	No	Continued from 2021
	By December 31, 2023, increase access to face-to-face interpretation, including VRI services, for LEP members in Molina's counties of operation.	No	Continued from 2021
	By December 31, 2023, increase the percentage of independent practice association providers rating their satisfaction with the availability of an appropriate range of interpreters as "Very Good" or "Excellent."	No	Continued from 2021
	By December 31, 2023, increase the percentage of members rating their satisfaction of providers' knowledge and sensitivity to disability diversity as "Very high," "High," or "Somewhat."	No	New in 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
Partnership	By December 31, 2022, create opportunities for sustainable employment for members by launching a community health worker scholarship program that engages representatives from traditionally underrepresented groups in Partnership's Northeast and Northwest regions and provides scholarships for at least 10 current or former members to support their enrollment into the Sacramento City College Community Health Worker Program.	Yes	New in 2022
	By December 31, 2022, support vulnerable members in preparing for disasters through a targeted telephonic outreach campaign and engage at least 25 percent of members identified as potential beneficiaries of the campaign.	No	New in 2022
	By December 31, 2022, improve the *Asthma Medication Ratio—Total* measure rate for pediatric members in the Northeast and Northwest regions.	Yes	Changed from 2021
	By March 1, 2023, increase the *Breast Cancer Screening—Total* measure rate among American Indians/Alaska Native members.	Yes	Changed from 2021
	By December 31, 2022, improve blood pressure control for members 18 to 85 years of age in the Black/African-American population.	Yes	New in 2022
	By March 1, 2023, increase the proportion of non-English-speaking/non-White members reporting grievances.	Yes	Changed from 2021
	By March 1, 2023, promote awareness and understanding of health equity by providing at least one diversity and inclusion training for Partnership employees.	Yes	Changed from 2021

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
SCAN	By December 31, 2022, increase the percentage of Spanish-speaking members with controlled diabetes.	Yes	Continued from 2021
	By December 31, 2022, increase the number of members assisted with accessing care and/or closing gaps in care.	No	Continued from 2021
	By September 2023, increase the percentage of Black members who receive the annual flu vaccine.	Yes	Changed from 2021
	By March 31, 2022, increase the cholesterol medication (statins) adherence rate for Hispanic members.	Yes	Continued from 2021
SCFHP	By December 31, 2023, close the disparity gap for adult Hispanic members with diabetes who have uncontrolled HbA1c levels.	Yes	New in 2022
	Develop an in-house health education class and curriculum for depression; and beginning January 1, 2023, offer the class to members at least once per quarter.	No	New in 2022
	Beginning January 1, 2023, receive quarterly interpreter data reports on language access provider services from a delegated network plan partner.	No	New in 2022
	By December 31, 2022, implement a language access provider satisfaction portal to capture telephonic interpreter feedback for monitoring.	No	New in 2022
SFHP	Decrease the percentage of members who have uncontrolled diabetes.	No	New in 2022
	Improve the *Breast Cancer Screening—Total* measure rate for Black/African-American members.	Yes	Continued from 2021
	Increase the percentage of members ages 0 to 15 months who have completed six or more well-child visits.	No	New in 2022
	Increase the rate for the member experience *Getting Needed Care* composite measure.	No	New in 2022

MCMC Plan Name	Objective Summary	Health Disparity (Yes/No)	Status
UHC	By June 1, 2022, deliver culturally appropriate member campaigns to reach a larger percentage of the member population (whose preferred language is not English), increasing the total number of HEDIS measures with rates meeting the minimum performance levels from eight measures in measurement year 2020 to 10 measures in measurement year 2021.	Yes	Continued from 2021
	By December 31, 2022, increase the *Prenatal and Postpartum Care—Postpartum Care* measure rate by supporting food security for postpartum care for the maternal health population using Mom's Meals.	Yes	Continued from 2021
	By December 31, 2022, increase the *Controlling High Blood Pressure—Total* measure rate by implementing a more integrated population health management approach to our members.	Yes	Continued from 2021

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

This appendix includes each MCMC plan's self-reported follow-up on the 2020–21 EQR recommendations and HSAG's assessment of the self-reported actions. Additionally, HSAG provides its assessment of each MCMC plan's strengths and weaknesses (referred to as "opportunities for improvement" in this appendix) related to 2021–22 EQR activities as well as HSAG's recommendations.

Aetna Better Health of California

Follow-Up on Prior Year Recommendations

Table E.1 provides EQR recommendations from Aetna's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.1 to preserve the accuracy of Aetna's self-reported actions.

Table E.1—Aetna's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. To ensure it identifies any failed data loads right away, Aetna should implement better monitoring and oversight processes for the MCMC plan's encounter data so that all encounter data are included for performance measure reporting.	Multiple actions have been implemented to ensure timely, accurate, and complete encounter data processes. ♦ Aetna Encounter Data Processes ■ Medical encounters are extracted weekly. ○ Encounters that pass validation go out in 837 encounter files. ○ Encounters that fail validation are held in internal exception until the MCMC plan's encounters unit resolves the issue. Once resolved, the encounter will go out in the 837 encounter file. (This is what has impacted our timeliness in the past.)

2020–21 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	■ Independent physician association (IPA) files are submitted weekly. ○ If the IPA file passes validation, the file is submitted to the state within 24 hours. ○ If the IPA file fails validation, we notify the IPA and send it the failed validation report. IPAs review, correct, and resubmit the corrected files. ■ Monthly meetings with IPAs to discuss performance and issue resolution. ○ Increased meeting frequency when performance falls below expected thresholds for three consecutive months. ○ In the event performance does not improve, Aetna may issue a CAP up to or including freezing member assignment and/or termination. All files are tracked within a file tracker.
2. For measures with rates below the minimum performance levels in measurement year 2020, Aetna should assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	Aetna has implemented various actions to improve performance on rates that were below the minimum performance levels in measurement year 2020, including but not limited to the following: ♦ Implemented new member welcome class to orient new members to programs and benefits ♦ Offered member rewards programs ■ Maternity Matters (pre/postpartum visits, perinatal visits, notice of pregnancy) ■ Aetna Better Care Rewards (women's screenings, child and adolescent immunizations, well-child visits, and blood lead screenings) ♦ Revamped all member mailers

2020–21 External Quality Review Recommendations Directed to Aetna	Self-Reported Actions Taken by Aetna during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ Expanded diabetes and maternal health population health programs ♦ Implemented Readmission Avoidance Program ♦ Developed health education program (in progress) ♦ Developed external-facing Aetna Better Health Quick Reference Guide that outlines Aetna's programs, incentives, and member outreach campaigns for provider awareness (also used for internal member-facing staff) ♦ Focused provider education efforts on lowest-performing provider offices ♦ Instituted a member management platform flag for open care gaps ♦ Conducted new electronic member outreach campaigns ♦ Enhanced the following member outreach reports: ■ Compliant Member Report ■ Initial Health Assessment Report ■ Blood Lead Screening Report ♦ Conducted a member preference survey regarding: ■ Communication preference ■ Contact information ■ Personal identification

Assessment of Aetna's Self-Reported Actions

HSAG reviewed Aetna's self-reported actions in Table E.1 and determined that Aetna adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. Aetna described in detail the steps it took to improve processes to ensure all encounter data are included for performance measure reporting. Aetna reported implementing member- and provider-focused interventions to

improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020, including:

- Conducted provider education for the lowest-performing clinics.
- Enhanced member outreach reports.
- Developed and implemented programs to improve members' awareness of and access to needed services.

The strategies Aetna implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Aetna" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Aetna

Based on the overall assessment of Aetna's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- A&I identified no findings during the 2021 State Supported Services Audit of Aetna.
- During the 2022 Medical Audit of Aetna, A&I identified no findings in the Quality Management category.
- The HSAG auditor determined that Aetna followed the appropriate specifications to produce valid performance measure rates for measurement year 2021.
- Aetna's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Chlamydia Screening in Women—Total* for San Diego County
  - *Prenatal and Postpartum Care—Postpartum Care* for San Diego County
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Sacramento County
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* and *Counseling for Nutrition—Total* for both reporting units
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* for both reporting units
    - For both reporting units, Aetna also performed above the high performance level for this measure.
- For both the *Diabetes Control* and *Well-Child Visits (Ages 3 to 11)* PIPs, Aetna met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.

- Aetna submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2021 Medical Audit of Aetna, A&I identified findings in all six categories and noted repeat findings in all categories except Utilization Management.
- During the 2022 Medical and State Supported Services Audit of Aetna, A&I identified findings in six of the seven categories reviewed. A&I identified repeat findings in the Case Management and Coordination of Care, Access and Availability of Care, and Member's Rights categories.
- For new supplemental data sources that Aetna submitted for measurement year 2021 reporting, the MCMC plan was unable to provide proof-of-service documentation for several of the cases the HSAG auditor chose for primary source verification. As a result, Aetna was unable to use two of the new supplemental data sources for measurement year 2021 reporting.
- For each reporting unit in measurement year 2021, Aetna performed below the minimum performance levels for 10 of the 15 measure rates that HSAG compared to benchmarks (67 percent).

2021–22 External Quality Review Recommendations

- Address the findings from the 2021 A&I Medical Audit of Aetna by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in all categories except Utilization Management.
- Address the findings from the 2022 A&I Medical and State Supported Services Audits of Aetna by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Case Management and Coordination of Care, Access and Availability of Care, and Member's Rights categories.
- Implement additional quality control processes to ensure supplemental data are appropriately compiled and available for performance measure reporting.
- For measures for which Aetna performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Aetna should determine whether the member- and provider-focused interventions described in Table E.1 need to be revised or abandoned based on intervention evaluation results.

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

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

AIDS Healthcare Foundation

Follow-Up on Prior Year Recommendations

Table E.2 provides EQR recommendations from AHF's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.2 to preserve the accuracy of AHF's self-reported actions.

Table E.2—AHF's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to AHF	Self-Reported Actions Taken by AHF during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. Work with DHCS to fully resolve the findings from the 2021 Medical Audit. AHF should thoroughly review all findings and implement the actions recommended by A&I.	AHF has worked with DHCS to fully resolve the findings from the 2021 Medical Audit. All findings and actions recommended by A&I have been reviewed. A CAP completed by AHF involved a detailed analysis, interventions, implementation, and monitoring. Monitoring continues as AHF waits for any additional concerns from DHCS or a response that final resolution is completed.

Assessment of AHF's Self-Reported Actions

HSAG reviewed AHF's self-reported actions in Table E.2 and determined that AHF adequately addressed HSAG's recommendation from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. AHF reported that the MCMC plan reviewed all 2021 Medical Audit findings and A&I recommended actions, and that AHF has taken steps to fully resolve all findings.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for AHF

Based on the overall assessment of AHF's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- While the CAP for the MCMC plan's 2021 A&I Medical Audit remains open as of the production of this report, AHF's self-reported actions as summarized in Table E.2 demonstrate that the MCMC plan has taken actions to address all findings identified by A&I.
- A&I identified no findings during the 2022 State Supported Services Audit of AHF.
- In response to the CAP from the 2022 Medical Audit of AHF, the MCMC plan provided documentation to DHCS regarding changes AHF made related to policies and procedures, training, and monitoring and oversight to address the audit findings. Upon review of AHF's documentation, DHCS closed the CAP.
- The HSAG auditor determined that AHF followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- AHF performed above the high performance level in measurement year 2021 for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure.
- For both the *Controlling High Blood Pressure* and *HIV Viral Load Suppression* PIPs, AHF met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- AHF submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- AHF's CAP from the 2021 A&I Medical Audit remains open as of the production of this report.

2021–22 External Quality Review Recommendations

- Continue to work with DHCS to fully resolve all findings from the 2021 A&I Medical Audit of AHF.

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

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

Alameda Alliance for Health

Follow-Up on Prior Year Recommendations

Table E.3 provides EQR recommendations from AAH's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.3 to preserve the accuracy of AAH's self-reported actions.

Table E.3—AAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. Continue to work with DHCS to fully resolve the findings from the 2019 Medical and State Supported Services Audits.	In January 2020, AAH provided supporting documents to DHCS related to our 2019 CAP; however, AAH has not received an official CAP closure notification.
2. Work with DHCS to resolve the findings from the 2021 Medical and State Supported Services Audits, paying particular attention to the repeat findings from the Medical Audit in the Utilization Management, Case Management and Coordination of Care, Member's Rights, and Administrative and Organizational Capacity categories.	♦ From November 2021 through May 2022, AAH provided supporting documents to DHCS related to our 2021 CAP. All action items for the repeat findings have been implemented. ♦ On August 4, 2022, DHCS reached out to AAH to request supporting evidence for some of the CAP items. AAH is expected to submit the response by August 15, 2022.
3. For measures with rates below the minimum performance levels in measurement year 2020 or for which AAH's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services	In 2020, AAH scored below the minimum performance level for measures as noted below: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*

2020–21 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
provided to members as well as barriers to accessing preventive and other health care services.	To address these two measures, AAH focused on getting children to see their PCPs for a well-care visit. This was done by employing two projects as indicated below: ♦ HEDIS Crunch Well-Care Visit—Ages 3 to 21 Years (September 2021 through December 2021)—In partnership with 20 pediatric/PCP sites, AAH conducted outreach to members ages 3 to 21 years and offered a $25 incentive to complete well-care visit exams. As a result, AAH's *Child and Adolescent Well-Care Visits—Total* measure rates improved. ♦ First 5 Alameda County—(July 2021 through June 2022)—In partnership with First 5, AAH conducted outreach to members ages 0 to 5 years. First 5 successfully contacted 1,551 members, and more than 900 members completed a well-care visit. As a result of the above efforts, AAH saw a substantial increase in rates for both the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measures. *Cervical Cancer Screening* PDSA ♦ Increase Access: AAH partnered with a high-volume, low-performing provider to offer Pap clinic days and increase access to cervical cancer screenings. As a result of the COVID Omicron variant, the provider was short staffed, and members were reluctant to go into clinics for health

2020–21 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	screenings. The intervention had limited success. *Breast Cancer Screening* Disparity PIP ♦ Member Outreach: Breast cancer screenings for women ages 50 to 74 years, with a focus on African American women. In partnership with a high-volume, low-performing provider, AAH conducted text messaging outreach and offered incentives to members who complete their breast cancer screening. This intervention is continuing through the end of 2022. *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*—Disease Self-Management Education ♦ Diabetes Health Coaching ■ In mid-2021, AAH launched a diabetes health coaching program to improve member HbA1c control through healthy eating, exercise, blood sugar monitoring, and access to care. Eligible members were referred upon completion of our Complex Case Management Program. Between July 1, 2021, and June 30, 2022, 13 members received coaching. ■ Health coaching will be expanded in 2022 to include a direct mail campaign inviting members to participate in multiple levels of care ranging from complex case management, health coaching, and receiving health education materials about diabetes. ♦ Incentivized diabetes class at FQHC: Incentive offered for member participation in FQHC diabetes self-management class.

2020–21 External Quality Review Recommendations Directed to AAH	Self-Reported Actions Taken by AAH during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Members are referred by their PCP or endocrinologist. As of August 1, 2022, 15 members participated in the first two-class series, and some of these members received the incentive for attending five of six classes. There will be a total of six classes in English and Spanish in 2022. ♦ American Diabetes Association Diabetes Self-Management Classes: AAH contracts with the Alameda County Public Health Department to provide the American Diabetes Association accredited diabetes self-management education. A total of 41 members with diabetes participated between July 1, 2021, and June 30, 2022. The program increased participation during COVID-19 restrictions by offering 1-to-1 telephonic education and support. ♦ Clinic/Hospital-Based Diabetes Self-Management Education Programs: AAH and its provider network promoted diabetes self-management education classes to members with diabetes through class listings mailed to members, the AAH website, and provider referral. Many programs address the cultural needs of members and provide geographic accessibility. More than 337 members attended clinic or hospital-based diabetes self-management programs at 11 different clinics and hospitals between July 1, 2021, and June 30, 2022.

Assessment of AAH's Self-Reported Actions

HSAG reviewed AAH's self-reported actions in Table E.3 and determined that AAH adequately addressed HSAG's recommendation from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. AAH indicated that the MCMC plan submitted documentation to DHCS but has not yet received closeout letters for the 2019 and 2021 A&I Medical and State Supported Services Audits. Additionally, AAH reported implementing member-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020, including:

- Conducted member outreach to encourage members to complete preventive care appointments.
- Offered member incentives for completing needed services.
- Implemented a diabetes health coaching program.
- Conducted diabetes health education classes.

The strategies AAH implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for AAH" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for AAH

Based on the overall assessment of AAH's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- While the CAPs for the MCMC plan's 2019 and 2021 A&I Medical and State Supported Services Audits remain open as of the production of this report, AAH's self-reported actions as summarized in Table E.3 demonstrate that the MCMC plan has taken actions to address all findings identified by A&I.
- During the 2022 Medical and State Supported Services Audits of AAH, A&I identified no findings in the Quality Management and State Supported Services categories.
- The HSAG auditor determined that AAH followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- AAH performed above the high performance levels for the following measures in measurement year 2021:
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*

♦ AAH's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*

♦ For both the *Breast Cancer Screening Among African Americans* Health Equity and *Child and Adolescent Well-Care Visits (Ages 3 to 21)* PIPs, AAH met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.

♦ AAH submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

♦ AAH's CAPs from the 2019 and 2021 A&I Medical and State Supported Services Audits remain open as of the production of this report.

♦ During the 2022 Medical Audit of AAH, A&I identified new and repeat findings in the Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Administrative and Organizational Capacity categories.

♦ AAH performed below the minimum performance levels in measurement year 2021 for the following three of 15 measure rates that HSAG compared to benchmarks (20 percent):
- *Breast Cancer Screening—Total*
- Both *Well-Child Visits in the First 30 Months of Life* measures

2021–22 External Quality Review Recommendations

♦ Continue to work with DHCS to fully resolve all findings from the 2019 and 2021 A&I Medical and State Supported Services Audits of AAH.

♦ Address the findings from the 2022 A&I Medical Audit of AAH by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in all five categories with findings.

- Assess whether the member outreach and incentive strategies described in Table E.3 to improve breast cancer screening rates need to be revised or abandoned based on AAH's performance for the *Breast Cancer Screening—Total* measure remaining below the minimum performance level in measurement year 2021.
- For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in AAH performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors.

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

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

Anthem Blue Cross Partnership Plan

Follow-Up on Prior Year Recommendations

Table E.4 provides EQR recommendations from Anthem Blue Cross' July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.4 to preserve the accuracy of Anthem Blue Cross' self-reported actions.

Table E.4—Anthem Blue Cross' Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. Improve supplemental data processes for future performance measure reporting, including: a. Implementing additional quality control processes to ensure supplemental data are appropriately compiled and available for reporting. b. Developing a summary document for its supplemental data sources which identifies the HEDIS Record of Administration, Data Management, and Processes (Roadmap) attachments that apply to multiple data sources, and providing these attachments separately and only once to consolidate the documentation and ensure a more efficient review. c. Investigating methods to incorporate supplemental data sources earlier in the audit process to eliminate the review of data sources that are not applicable to the measures under the scope of the audit.	1.a. We have continued to enhance our quality control processes by enhancing our primary source verification processes for non-standard sources, in particular for Consolidated Clinical Document Architecture data sources. We significantly expanded the volume of internal reviews as well as strengthened the collaboration with the represented providers. 1.b. We significantly improved the Section 5 documentation and provided all documentation in a consolidated document. While we are very proud of the progress we have made in the past year, we acknowledge that there is still work to be done to further simplify and enhance the process on our side for optimal transparency for both our auditors as well as our downstream customers. 1.c. We enhanced our process this year by attempting to eliminate sources that were not applicable. For the upcoming audit season, we intend to start even earlier and work with our data partners to further consolidate and simplify. We will begin submitting Consolidated

2020–21 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Clinical Document Architecture data sources for primary source verification in November 2022 for measurement year 2022 with the hope of completing Consolidated Clinical Document Architecture data primary source verification as early as possible. We have a new process to ingest any new Data Aggregator Validation certified sources we come across for measurement year 2022 and beyond.
2. For measures with rates below the minimum performance levels in measurement year 2020 or for which Anthem Blue Cross' performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	Factors that contributed to the decline in rates from measurement year 2019 to measurement year 2020 were primarily due to the COVID-19 shelter-in-place orders that were compounded by the health care emergency California State recommendations. Some provider offices had closed, and Anthem Blue Cross associates were not allowed to enter open facilities to capture medical records. Additionally, to ease the burden on our provider network, Anthem Blue Cross associates were restricted from calling/faxing open offices to request they return records due to the stresses the offices were under trying to deal with the health care emergency. California regions were some of the hardest hit areas in the early stages of the pandemic. **Actions taken by Anthem Blue Cross during July 1, 2021, through June 30, 2022:** ♦ Anthem Blue Cross completed staff restructuring in 2021 to have a dedicated provider-facing Care Delivery Transformation Team. This allows strategic focus on improving access to services and completion of specific services to improve quality measure rates. Additionally, a specialized Member Engagement Team

2020–21 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	has been created to do member reminder contacts. ♦ The Member Engagement Team conducted outreach calls in 2021 to hundreds of thousands of members to remind them of needed services. Health Crowd (Mpulse) Interactive Voice Response (IVR) call campaigns with informative/educational messages for childhood measures (*Child and Adolescent Well-Care Visits—Total*, *Childhood Immunization Status—Combination 10*, *Immunizations for Adolescents—Combination 2*, and both *Well-Child Visits in the First 30 Months of Life* measures); chronic disease measures (*Comprehensive Diabetes Care—Hemoglobin A1c [HbA1c] Poor Control [>9.0 Percent]—Total* and *Controlling High Blood Pressure—Total*); and women's health measures (*Breast Cancer Screening—Total*, *Cervical Cancer Screening*, and both *Prenatal and Postpartum Care* measures) restarted in Q1 2021. In 2022, Anthem Blue Cross will expand the scope to include member home visits. ♦ In 2021, Anthem Blue Cross implemented the Healthy Rewards Program to encourage members to complete needed services for the following measures: ■ Both *Antidepressant Medication Management* measures ■ *Breast Cancer Screening—Total* ■ *Cervical Cancer Screening* ■ *Child and Adolescent Well-Care Visits—Total* ■ *Childhood Immunization Status—Combination 10*

2020–21 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	■ All three *Chlamydia Screening in Women* measures ■ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* ■ *Controlling High Blood Pressure—Total* ■ Both *Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication* measures ■ *Immunizations for Adolescents—Combination 2* ■ Both *Prenatal and Postpartum Care* measures ■ Both *Well-Child Visits in the First 30 Months of Life* measures ♦ In 2021, Anthem Blue Cross mailed toolkits to members with chronic diseases that included a blood pressure monitor, thermometer, oximeter, and scale to assist with home monitoring for chronic disease conditions. ♦ In 2021 Quarter 4, Anthem Blue Cross executed a contract with COZEVA to provide clinics a user-friendly data interface. This tool facilitates timely member-specific information to help clinicians identify services needed to meet compliance for HEDIS measures. Currently, 609,000 members are included in the initial opportunity to participate for our provider network. ♦ In 2020 Quarter 4 and 2021, Anthem Blue Cross mailed Quest HbA1c home test kits to assist with HbA1c compliance. ♦ In 2020 and 2021, Anthem Blue Cross implemented an annual provider incentive program to encourage timely completion of

2020–21 External Quality Review Recommendations Directed to Anthem Blue Cross	Self-Reported Actions Taken by Anthem Blue Cross during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	needed services and to increase compliance. ♦ In 2020 and 2021, Anthem Blue Cross increased its focus on supplemental data collection and including biometric results such as blood pressure and HbA1c results. ♦ In 2020 and 2021, Anthem Blue Cross improved its access to remote EHRs to limit the medical records access barrier we experienced during the health care emergency.

Assessment of Anthem Blue Cross' Self-Reported Actions

HSAG reviewed Anthem Blue Cross' self-reported actions in Table E.4 and determined that Anthem Blue Cross adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. Anthem Blue Cross described in detail the steps it took to improve supplemental data processes for future performance measure reporting. Anthem Blue Cross attributed the decline in the MCMC plan's performance from measurement year 2019 to measurement year 2020 to the COVID-19 shelter-in-place orders that were compounded by California's State health care emergency recommendations. Anthem Blue Cross reported implementing member- and provider-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020, including:

- Restructured the MCMC plan's staffing to improve member access to needed services.
- Conducted member outreach.
- Offered member incentives.
- Provided at-home resources to members with chronic diseases (HbA1c testing kit, blood pressure monitor, thermometer, oximeter, scale, etc.).
- Contracted with a vendor to provide a tool to clinics that helps clinicians identify which services each member needs to meet compliance for performance measure requirements.
- Implemented a provider incentive program.

The strategies Anthem Blue Cross implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review

Activities Strengths, Opportunities for Improvement, and Recommendations for Anthem Blue Cross" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Anthem Blue Cross

Based on the overall assessment of Anthem Blue Cross' delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- During the 2021 Medical and State Supported Services Audits of Anthem Blue Cross, A&I identified no findings in the Member's Rights, Quality Management, and State Supported Services categories.
- The HSAG auditor determined that Anthem Blue Cross followed the appropriate specifications to produce valid performance measure rates for measurement year 2021.
- Across all reporting units for measure rates that HSAG compared to benchmarks in measurement year 2021, Anthem Blue Cross' performance:
  - Was above the high performance levels for 19 rates.
  - Moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021 for 44 rates.
- For both the *Cervical Cancer Screening Among Vietnamese Members* Health Equity and *Childhood Immunizations* PIPs, Anthem Blue Cross met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- Anthem Blue Cross submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2021 Medical Audit of Anthem Blue Cross, A&I identified findings in the Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, and Administrative and Organizational Capacity categories.
- Based on the previous year's recommendations, Anthem Blue Cross worked to improve and consolidate its Roadmap supplemental data source documentation; however, the MCMC plan's initial Roadmap documentation did not include all necessary information for each data source. Although Anthem Blue Cross ultimately provided the needed Roadmap documentation, more comprehensive documentation should be provided with the MCMC plan's initial Roadmap submission.
- Across all reporting units in measurement year 2021, Anthem Blue Cross performed below the minimum performance levels for 75 of the 180 measure rates that HSAG compared to benchmarks (42 percent).

2021–22 External Quality Review Recommendations

- Address the findings from the 2021 A&I Medical Audit of Anthem Blue Cross by implementing the actions recommended by A&I.
- To ensure that its Roadmap documentation for supplemental data sources is comprehensive and includes all necessary information prior to submitting for review, Anthem Blue Cross should:
  - Continue to implement additional quality control processes to ensure supplemental data are appropriately compiled and available for reporting.
  - Develop a flowchart or summary document for its supplemental data sources that identifies the Roadmap attachments which apply to multiple data sources and provide these attachments separately and only once to the auditor to consolidate the documentation and ensure a more efficient review.
  - Continue to investigate methods to incorporate supplemental data sources earlier in the audit process to eliminate the review of data sources that are not applicable to the measures and population being audited.
- For measures for which Anthem Blue Cross performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Anthem Blue Cross should determine whether the member- and provider-focused interventions described in Table E.4 need to be revised or abandoned based on intervention evaluation results.

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

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

Blue Shield of California Promise Health Plan

Follow-Up on Prior Year Recommendations

Table E.5 provides EQR recommendations from Blue Shield Promise's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.5 to preserve the accuracy of Blue Shield Promise's self-reported actions.

Table E.5—Blue Shield Promise's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that the MCMC plan fully resolves all findings from the 2021 DHCS A&I Medical Audit, paying particular attention to the repeat findings in the Access and Availability of Care, Member's Rights, and Quality Management categories.	CAPs were developed and implemented. The MCMC plan worked closely with DHCS to provide all requested information and updates. DHCS closed the CAPs in May 2022.
2. For measures with rates below the minimum performance levels in measurement year 2020 or for which Blue Shield Promise's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	In 2020, Blue Shield Promise saw a significant decline in performance across several measures, including all three *Chlamydia Screening in Women* measures, *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*. In addition, Blue Shield Promise performed below the minimum performance levels on the following measures in Measurement Year 2020: ♦ *Asthma Medication Ratio—Total* ♦ *Breast Cancer Screening—Total* ♦ *Cervical Cancer Screening* ♦ *Child and Adolescent Well-Care Visits—Total*

2020–21 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* ♦ *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* ♦ *Immunizations for Adolescents—Combination 2* ♦ Both *Well-Child Visits in the First 30 Months of Life* measures The COVID-19 pandemic affected performance on all of these measures. Due to the pandemic, a high number of providers across the network prioritized sick visits over preventive health visits to best meet the needs of their populations. There was also a high level of member fear to go into provider offices or labs to complete routine appointments and follow-up visits. Blue Shield Promise implemented a variety of interventions to help address performance on these measures and further support members with getting back into their provider offices for preventive care. In the last quarter of 2020, Blue Shield Promise piloted a health navigator program, which placed a Blue Shield Promise staff member in high-volume clinics within San Diego County. This navigator's goal was to focus on member engagement and education, addressing COVID-19 fears centered around coming into the provider office and assisting members with scheduling preventive visits and follow-up visits to address chronic conditions such as diabetes and asthma. The navigator

2020–21 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	also focused on improving provider process flows to enable providers to normalize operations as much as possible during this period. Throughout 2021, this program was expanded to cover more than 50 percent of the Medi-Cal membership in San Diego County. By March 2022, the health navigator program expanded to cover more than 85 percent of the Medi-Cal membership in San Diego County, with one health navigator specifically focused on improving breast cancer screening rates. Beginning in March 2021, Blue Shield Promise's HEDIS outreach team conducted live outreach calls to members with open care gaps inclusive of the measures with rates falling below the minimum performance levels. These outbound calls are continuing into 2022. In addition, we have been working in 2021 and 2022 on a member services platform that enables a more high-touch experience, including functionality that supports member services representatives speaking to members about important preventive visits and other care gaps, including asthma medications, and assisting with scheduling these appointments as needed. Beginning in Quarter 2 2021, Blue Shield Promise implemented additional clinic days, weekend clinics, and after-hours appointments to expand appointment availability for child and adolescent well-child visits (inclusive of childhood immunizations, adolescent immunizations, and chlamydia screening); cervical cancer screening; and breast cancer screening. Blue Shield Promise also contracted with an additional mobile mammogram vendor in Quarter 4 2021 to ease

2020–21 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	access to mammogram services throughout the county for members. Member incentives were also expanded beginning in Quarter 3 2021 to impact more measures and members across San Diego County. Blue Shield Promise noted that members have been receptive to incentive programs and is therefore expanding programs even further in 2022. Furthermore, in Quarter 4 2021 the health education department offered English/Spanish diabetes classes for diabetic members who were historically non-compliant to get them re-engaged in their health care. Members were encouraged to participate in these classes and provided with a member incentive for doing so. In late 2020 through Quarter 3 2021, Blue Shield Promise partnered with a vendor to provide diabetes screening to members with schizophrenia or bipolar disorder who were being prescribed antipsychotic medications. In 2021, to improve our performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure, Blue Shield Promise continued to promote the use of Pregnancy Notification Forms (PNFs) with provider groups. Blue Shield Promise worked closely with our maternity care program to follow up with pregnant members identified on these forms to ensure that members receive immediate support for their pregnancy, attend their prenatal care visits, and receive the necessary education and resources throughout their pregnancy and postpartum. Through implementing these programs and working closely with our network providers in

2020–21 External Quality Review Recommendations Directed to Blue Shield Promise	Self-Reported Actions Taken by Blue Shield Promise during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	San Diego County, Blue Shield Promise is seeing an improvement across these measures and continues to monitor their progress.

Assessment of Blue Shield Promise's Self-Reported Actions

HSAG reviewed Blue Shield Promise's self-reported actions in Table E.5 and determined that Blue Shield Promise adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. Blue Shield Promise stated that it worked closely with DHCS to fully resolve all findings from the 2021 A&I Medical Audit, resulting in DHCS closing the CAP in May 2022. Blue Shield Promise indicated that COVID-19 negatively impacted measurement year 2020 performance measure rates and described member- and provider-focused interventions the MCMC plan implemented to improve member access to needed services, including:

- Piloted a health navigator program in high-volume clinics in San Diego County and expanded the program to cover more than 85 percent of Blue Shield Promise's membership in San Diego County.
- Worked with providers to improve clinic process flow.
- Conducted live outreach calls to members with care gaps related to measures with rates below the minimum performance levels.
- Offered additional clinic days, weekend clinics, and after-hours appointment times for screening and preventive services.
- Expanded the MCMC plan's member incentive program.

The strategies Blue Shield Promise implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Blue Shield Promise" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Blue Shield Promise

Based on the overall assessment of Blue Shield Promise's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- In response to the CAP from the 2021 A&I Medical Audit of Blue Shield Promise, the MCMC plan provided documentation to DHCS that resulted in DHCS closing the CAP.
- During the 2022 Medical and State Supported Services Audits of Blue Shield Promise, A&I identified no findings in the Administrative and Organizational Capacity and State Supported Services categories.
- The HSAG auditor determined that Blue Shield Promise followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- Blue Shield Promise performed above the high performance level in measurement year 2021 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measure.
- Blue Shield Promise's performance for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure moved from below the minimum performance level in measurement year 2020 to above the minimum performance level in measurement year 2021.
- For both the *Childhood Immunizations Among Non-Hispanic Members* Health Equity and *Well-Child Visits in the First 30 Months of Life* PIPs, Blue Shield Promise met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- Blue Shield Promise submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2022 Medical Audit of Blue Shield Promise, A&I identified findings in the Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management categories and noted repeat findings in all categories except Case Management and Coordination of Care.
- Blue Shield Promise performed below the minimum performance levels in measurement year 2021 for the following six of 15 measure rates that HSAG compared to benchmarks (40 percent):
  - *Breast Cancer Screening—Total*
  - *Cervical Cancer Screening*
  - *Child and Adolescent Well-Care Visits—Total*
  - *Immunizations for Adolescents—Combination 2*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

2021–22 External Quality Review Recommendations

- Address the findings from the 2022 A&I Medical Audit of Blue Shield Promise by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Utilization Management, Access and Availability of Care, Member's Rights, and Quality Management categories.
- For measures for which Blue Shield Promise performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Blue Shield Promise should determine whether the member- and provider-focused interventions described in Table E.5 need to be revised or abandoned based on intervention evaluation results.

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

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

California Health & Wellness Plan

Follow-Up on Prior Year Recommendations

Table E.6 provides EQR recommendations from CHW's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.6 to preserve the accuracy of CHW's self-reported actions.

Table E.6—CHW's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. To ensure CHW's processes for identifying dual-eligible exclusions for the Medicaid population are complete, update the MCMC plan's exclusion methodology to meet the National Committee for Quality Assurance requirements to exclude dual-eligible Medicaid members with either (1) both Medicare Part A and Part B or (2) Medicare Part C coverage.	After consulting with our auditor and NCQA, it was determined that we should exclude full duals and members with Part B coverage. Medicare Part A coverage enrollment spans were added back into our Medi-Cal projects for measurement year 2021. Any removal of data is done at the enrollment span level (i.e., we only remove the span tied to full dual or Part B coverage). Members may ultimately still count toward certain measures.
2. For measures with rates below the minimum performance levels in measurement year 2020 or that declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected CHW's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	For measures with rates below the minimum performance levels in measurement year 2020 or that declined significantly from measurement year 2019 to measurement year 2020, CHW has implemented initiatives to address timeliness and quality of services provided to members as noted in the MCMC plan's Quality Work Plan. A few examples are listed below. ♦ Annual HEDIS Unit Family Outreach Initiative: Member outreach focused on live calls with an offer of a warm transfer to the member's PCP to schedule a visit to close care gaps for the MCAS measures. ♦ Mobile Mammography: This program partners with providers/clinic sites to expand

2020–21 External Quality Review Recommendations Directed to CHW	Self-Reported Actions Taken by CHW during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	convenient access to breast cancer screenings via mobile mammography to address barriers and access to care. Equipment (via mobile unit or portable coach) and state licensed technicians are provided by contracted vendors to conduct the breast cancer screenings. ♦ One-Stop Clinics: One-stop clinics provide clinical care during extended clinic hours (hours outside of a provider's regular business hours or during a set block of time during the week dedicated to CHW members), such as evenings and weekends, and can bring additional services on-site to address multiple care gaps at once. ♦ Member Engagement Incentive Program: Point-of-care gift card for members engaging with their providers and accessing care.

Assessment of CHW's Self-Reported Actions

HSAG reviewed CHW's self-reported actions in Table E.6 and determined that CHW adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. CHW reported taking the needed steps to ensure the MCMC plan's processes for identifying dual-eligible exclusions for the Medicaid population are complete for performance measure reporting. Additionally, CHW described initiatives the MCMC plan implemented that were designed to improve the timeliness and quality of services provided to CHW members, including:

- Conducted live outreach calls and connected members with their PCPs to schedule needed health care appointments.
- Partnered with providers to offer mobile mammography.
- Implemented one-stop clinics that offered extended hours and comprehensive services.
- Offered member incentives to members who engaged with their providers and accessed needed services.

The strategies CHW implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for CHW" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for CHW

Based on the overall assessment of CHW's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- ♦ During the 2021 Medical and State Supported Services Audits of CHW, A&I identified no findings in five of the six categories reviewed. Additionally, in response to the CAP from these audits, CHW provided documentation to DHCS regarding changes the MCMC plan made related to the findings A&I identified in the Access and Availability of Care category. CHW made changes related to policies and procedures and implementation/oversight and monitoring. Upon review of CHW's documentation, DHCS closed the CAP.
- ♦ The HSAG auditor determined that CHW followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- ♦ For both Region 1 and Region 2, CHW performed above the high performance level for the *Prenatal and Postpartum Care—Postpartum Care* measure in measurement year 2021.
- ♦ CHW's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - ■ *Cervical Cancer Screening* in Imperial County
  - ■ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* in Region 1 and Region 2
  - ■ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in Imperial County and Region 2
  - ■ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* in Region 1 and Region 2
  - ■ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Nutrition—Total* in Imperial County
- ♦ For both the *Breast Cancer Screening Among Members Living with Disabilities in Region 1* Health Equity and *Childhood Immunizations* PIPs, CHW met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- ♦ CHW submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- ♦ Across all reporting units in measurement year 2021, CHW performed below the minimum performance levels for 24 of the 45 measure rates that HSAG compared to benchmarks (53 percent).

2021–22 External Quality Review Recommendations

- ♦ For measures for which CHW performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, CHW should determine whether the member- and provider-focused interventions described in Table E.6 need to be revised or abandoned based on intervention evaluation results.

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

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

CalOptima

Follow-Up on Prior Year Recommendations

Table E.7 provides EQR recommendations from CalOptima's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.7 to preserve the accuracy of CalOptima's self-reported actions.

Table E.7—CalOptima's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For measures with rates below the minimum performance levels in measurement year 2020 or for which CalOptima's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	**Pediatric Measures** In review of the July 1, 2020, through June 30, 2021, MCMC plan-specific performance evaluation report for CalOptima, child measures maintained the minimum performance levels and showed sustainability across all measures. As children were still required to have vaccinations for school entry requirements, this may have contributed to a sustained performance in pediatric measures. Having member health rewards for the *Well-Child Visits in the First 15 Months of Life* and *Adolescent Well-Care Visits* measures running in 2020 may have helped contribute to members determining to be seen by their providers even during the pandemic. In addition, from July 1, 2021, through June 30, 2022, additional concerted strategies were implemented, including texting, IVR, printed ad, digital ad, social media targeted campaigns, back-to-school vaccination events, and newsletter communications to members to prioritize well-child visits, vaccinations, and preventive care.

2020–21 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Women's Measures Women's measures for preventive care, including cancer screening, chlamydia screening, contraceptive care for specific age bands, and timeliness of prenatal care all showed a statistically significant decline, which can likely be accounted for by the impact of COVID-19 pandemic limitations on accessing care for in-office visits. It may also be attributed to the lack of knowledge or lack of utilization of telehealth visits which began to take shape after the first or second quarter of the pandemic. Cervical cancer screening was an area that took the greatest hit, and since then, multi-modal member engagement strategic interventions have been put into play including social media targeted campaigns, digital targeted ads, targeted mailings, texting campaigns, member newsletters, and an IVR robocall campaign. CalOptima also collaborated with health network quality partners to help identify patients and to conduct outreach to non-compliant members. After the increase in telehealth visits permitted dialogue between members and providers, utilization and the willingness to perform procedures which could only be completed in person, such as a mammograms or chlamydia screenings requiring a lab sample, were impacted. In addition, from July 1, 2021, through June 30, 2022, additional concerted strategies were implemented to support prenatal care, including printed ad; digital ad; social media targeted campaigns; new parent resource fairs to augment awareness of prenatal care, CalOptima's Bright Steps maternal health program, and community resources that support a healthy pregnancy; and newsletter

2020–21 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	communications to providers. Future strategies will involve targeted texting campaigns. **Behavioral Health** The July 1, 2020, through June 30, 2021, MCMC plan-specific performance evaluation report identified a decline in performance for the *Screening for Depression and Follow-Up Plan—Ages 12–17 Years* and *Ages 18–64 Years* measures. Access to routine care has been impacted overall since the onset of the COVID-19 pandemic. This decline may be attributed to patients delaying or foregoing care because of concerns and fear of becoming infected. The pandemic also posed as a barrier to planned activities intended to improve rates. The measure relies on providers using identified codes indicating whether the measure has been met. Provider educational events were placed on hold in 2020 as a result of the pandemic. CalOptima updated member materials to distribute to providers so that they could share the materials with members in their offices at the time of the visits. Due to stay-at-home orders, providers were forced to shift quickly from in-office visits to telehealth visits. This transition may have also impacted the rates. CalOptima was able to continue to provide education to members, raising awareness about the importance of screenings, treatment adherence, and follow-up care. Member education was conducted through social media posts and member newsletters. The behavioral health integration department also created a short video to further raise awareness on accessing care and connecting with providers to address symptoms of depression.

2020–21 External Quality Review Recommendations Directed to CalOptima	Self-Reported Actions Taken by CalOptima during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Acute and Chronic Diseases While chronic disease measures fared relatively well over this period, the rate for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure increased, which means poorer control. This was expected as members were not only unwilling and unable to go to in-person provider visits, they were also unwilling and unable to go to the labs to obtain blood draws to test HbA1c levels. The *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure rate inevitably worsened as values were not available, and results also likely worsened with compounding factors contributing to poorer health and less monitored treatment for members with diabetes and other comorbidities. This was one of the top segments of the chronic and acutely ill population which was at highest risk with the COVID-19 threat. For members with diabetes, CalOptima implemented targeted mailings, social media campaigns, printed ads, newsletters, an IVR robocall campaign, health coach outreach, and HbA1c testing health rewards to help motivate behavior change and emphasize the importance of not only medication adherence but seeking regular treatment through and after this measurement period. In addition, emphasis on statin treatment and medication adherence is the focus of a letter and health coach call campaign targeting members with diabetes with HbA1c levels previously under 8 percent who now have HbA1c levels above 9 percent. These members have been referred to health coaches for motivational interviewing and advisement on the importance of self-management.

Assessment of CalOptima's Self-Reported Actions

HSAG reviewed CalOptima's self-reported actions in Table E.7 and determined that CalOptima adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. For measures with rates below the minimum performance levels in measurement year 2020 or for which CalOptima's performance declined significantly from measurement year 2019 to measurement year 2020, CalOptima provided details regarding the factors it identified that resulted in the decline in performance, most of which were related to COVID-19. Additionally, CalOptima described provider- and member-focused interventions the MCMC plan implemented to improve performance on measures, including:

- Conducted member education and outreach via texting, IVR, printed ads, digital ads, social media, and newsletters.
- Implemented back-to-school vaccination events.
- Collaborated with health network quality partners to identify members with care gaps and conducted targeted outreach to those members.
- For members with diabetes, conducted health coach outreach and offered incentives for HbA1c testing completion to help motivate behavior change and support self-management.

The strategies CalOptima implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for CalOptima" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for CalOptima

Based on the overall assessment of CalOptima's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- During the 2022 Medical and State Supported Services Audits of CalOptima, A&I identified no findings in the Administrative and Organizational Capacity and State Supported Services categories.
- The HSAG auditor determined that CalOptima followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- CalOptima performed above the high performance levels for the following measures in measurement year 2021:
  - *Chlamydia Screening in Women—Total*

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
- *Controlling High Blood Pressure—Total*
- *Immunizations for Adolescents—Combination 2*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*

- ♦ CalOptima's performance for the *Cervical Cancer Screening* measure moved from below the minimum performance level in measurement year 2020 to above the minimum performance level in measurement year 2021.
- ♦ For both the *Breast Cancer Screening Among Chinese and Korean Members* Health Equity and *Well-Child Visits in the First 15 Months of Life* PIPs, CalOptima met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- ♦ CalOptima submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- ♦ During the 2022 Medical Audit of CalOptima, A&I identified findings in all categories except Administrative and Organizational Capacity.
- ♦ CalOptima performed below the minimum performance levels in measurement year 2021 for both *Well-Child Visits in the First 30 Months of Life* measures.

2021–22 External Quality Review Recommendations

- ♦ Address the findings from the 2022 A&I Medical Audit of CalOptima by implementing the actions recommended by A&I.
- ♦ For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in CalOptima performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors. As part of this assessment, CalOptima should determine whether the member-focused interventions described in Table E.7 need to be revised or abandoned based on intervention evaluation results.

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

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

CalViva Health

Follow-Up on Prior Year Recommendations

Table E.8 provides EQR recommendations from CalViva's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.8 to preserve the accuracy of CalViva's self-reported actions.

Table E.8—CalViva's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. Continue to work with DHCS to ensure CalViva has taken all required actions to fully resolve the findings from the 2020 Medical Audit.	**Finding 2.1. RE: Completion of Individual Health Education Behavior Assessments (IHEBAs) and IHA** Medical Management has continued its efforts to improve IHA and IHEBA completion in Fresno, Kings, and Madera counties since the 2020 DHCS Medical Audit through the following efforts: ♦ Continued our plans to follow the quality improvement process to increase IHA/IHEBA completion using PDSA and rapid-cycle improvement. ♦ Our multidisciplinary IHA Improvement Team worked with the local FQHC team members to test potential improvement strategies and collaboratively identified best practices for IHA completion to share with all CalViva providers (July 2021). The best practice strategies include: ■ Standardized new member identification and outreach methodology and user-friendly tool for documenting outreach attempts (July 2021) ■ Identified and established a designated Current Procedural Terminology (CPT) code to be used for claims/encounters

2020–21 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	tracking when an IHA/IHEBA has been completed (July 2021) ■ Created and utilized provider engagement training materials for rollout of best practices in Fresno, Kings, and Madera counties with: ○ 200 provider sites trained in October 2021 ○ 87 trained in November 2021 ○ 21 trained in December 2021 ○ Total of 308 provider sites trained (completed Quarter 4 2021) ♦ To monitor our success, CalViva developed and continues to refine our IHA Quarterly Report. As part of that report, each quarter, low-performing providers are identified and contacted by CalViva's provider engagement staff members to determine what support is needed to improve their compliance. ♦ In August 2021, seven high-volume, low-compliance providers were identified, and retraining/review was completed by October 27, 2021. This process is ongoing. ♦ An information technology enhancement has been initiated to identify the 10 lowest-performing providers to target for education regarding IHA/IHEBA compliance (June 2022). ♦ Provider tip sheet was updated in March 2022 and was made available through the provider portal and distributed or emailed by provider engagement staff members to providers receiving HEDIS/health education training. Each tip sheet outlines DHCS' requirements, recommended service codes, best practices, and tips for completing the new member IHA.

2020–21 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ Provider engagement staff members routinely provide education and trainings or troubleshooting for provider offices and staff when new staff members are hired, or to provide tips for completing the IHA, best practices, and recommended service codes. (Ongoing) ♦ COVID-19 impacted our improvement activities associated with IHA/IHEBA. Although we continued with our efforts, DHCS' All Plan Letter (APL) 20-004 temporarily halted requirements to complete the IHA from December 1, 2019, until the end of the public health emergency and is still ongoing. Routine visits by members have decreased, provider office sites have been closed, staff shortages, and telehealth have all impacted the success of our interventions. **Finding 3.1.1 RE: Policies and procedures to bring non-compliant entities into compliance with appointment availability and access standards** As noted in CalViva's 2019–20 MCMC plan-specific-performance evaluation report, finding 3.1.1 was approved for closure on August 28, 2020.
2. Continue working with NCQA to ensure CalViva's processes for identifying dual-eligible exclusions for the Medicaid population are complete by updating its exclusion methodology to meet NCQA requirements to exclude dual-eligible Medicaid members with either (1) both Medicare Part A and Part B or (2) Medicare Part C coverage.	After consulting with our auditor and NCQA, it was determined that we should exclude full duals and Part B coverage. Medicare Part A coverage enrollment spans were added back into our Medi-Cal projects for measurement year 2021. Any removal of data is done at the enrollment span level (i.e., we only remove the span tied to full dual or Part B coverage). Members may ultimately still count toward certain measures.

2020–21 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
3. For measures with rates below the minimum performance levels in measurement year 2020 or for which CalViva's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	Measurement year 2020 final performance measure results indicate that several measures did not meet the minimum performance levels or had a significant decline from the prior year. A number of factors were identified that affected performance for these measures, including COVID-19. COVID-19-related barriers in general relate to provider office closures, members' fears and perceptions about care, delaying preventive care, and staffing turnover and shortages, which all resulted in lower utilization of care. As a plan, CalViva supported COVID-19 vaccination incentives, engaged offices with community health care workers, and conducted live outreach calls to parents/guardians of households to offer help with scheduling a doctor's visit, as well as linking members to health plan benefits and community resources. CalViva implemented three strategies targeting different HEDIS measures to mitigate the impact of COVID-19: ♦ The first strategy used live outreach calls to members in Kings and Madera counties who were prescribed an antidepressant medication, diagnosed with major depression, and showing gaps in their antidepressant medication refills between 15 and 50 days. The live outreach calls supported medication adherence and provided additional resources to members with depression. ♦ The second strategy was the Medication Adherence Pharmacy Outreach Program targeting members with diabetes and hypertension in Fresno and Madera counties. Both Fresno and Madera counties saw declines in performance for the

2020–21 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total and *Controlling High Blood Pressure—Total* measures from measurement year 2019 to measurement year 2020. A pharmacist called members who were non-compliant for these measures between October 2021 and January 2022. The pharmacist used motivational interviewing techniques to understand the individual barriers to compliance and assist with medication adherence through dialogue and by contacting the member's pharmacy and/or provider when needed to address identified issues. ♦ The third strategy was a pediatric household outreach live call that targeted all pediatric care gaps for all members in one household. The measures targeted included: ■ *Child and Adolescent Well-Care Visits—Total* ■ *Childhood Immunization Status—Combination 10* ■ All three *Chlamydia Screening in Women* measures ■ *Immunizations for Adolescents—Combination 2* ■ Both *Well-Child Visits in the First 30 Months of Life* measures For a select prioritized set of measures, CalViva conducted in-depth quality improvement projects. This included measures related to diabetes care, breast cancer screening, childhood immunizations, and cervical cancer screening.

2020–21 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	To address performance decline on the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure, a PDSA cycle was implemented (November 15, 2021, through July 15, 2022), in collaboration with an FQHC in Fresno County to assist CalViva diabetic members with elevated HbA1c levels to control and maintain their blood glucose levels within a healthy range, thereby minimizing the long-term risks and complications associated with this highly prevalent chronic disease. ♦ The priority barrier the first PDSA cycle addressed was to reengage non-compliant diabetic members assigned to the targeted clinic by first reminding them of the importance and purpose of lab testing related to their diabetes. Following the reminder, these members were offered dietitian-led classes and one-on-one counseling to assist with dietary and physical activity changes to improve blood glucose levels. Other barriers addressed included scheduling challenges, child care, and transportation. ♦ The team developed three workflows as they progressed through this rapid-cycle improvement project in order to capture: ■ Engaging members and facilitating completion of HbA1c testing and some initial education using an approved Stoplight tool. ■ Scheduling and completing three face-to-face nutrition classes with a dietitian followed by three one-on-one sessions with the dietitian. ■ Distributing a link via email/text in order to view a video of the three nutrition

2020–21 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	classes referenced above to interested diabetic members in our targeted population, followed by scheduling and completing three one-on-one sessions with the dietitian (June 2022). ♦ The team discovered that multiple training options are required to meet the needs of diabetic members today. More testing is needed to fully assess outcomes of these efforts; however, much was learned and will be used going forward. A PIP was implemented to address performance on the *Breast Cancer Screening—Total* measure. ♦ CalViva's Medical Management Team is collaborating with an FQHC, a women's breast imaging center, and a local community-based organization in Fresno County to improve breast cancer screening completion rates. The FQHC has a high volume of Hmong and Laotian patients who were found to have low mammogram rates. ♦ SMART Aim: By December 31, 2022, use key driver diagram interventions to increase the breast cancer screening rate among the Hmong-, Laotian-, and Khmer-speaking female populations ages 50 to 74 years and assigned to the FQHC targeted sites in Fresno County. ♦ Based on the barrier analysis, a health education session was developed to address health literacy issues among the Southeast Asian population. However, attempting to contact women after the educational event to schedule a mammogram proved very challenging. ♦ A second intervention, mobile mammography events, was implemented at

2020–21 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	the FQHC with much greater success. CalViva's "member friendly approach" adopted for the educational event addressed cultural, language, transportation, and other potential barriers. As part of this approach, transportation was offered to all members and interpreter services were available on-site for the targeted population who all listed a language other than English as their primary language. On-site education was provided to members in their language before the exam, and a $25 gift card was provided at completion. To address the performance on the *Childhood Immunization Status—Combination 10* measure, CalViva implemented a PIP with the goal of improving the health and safety of our youngest children and other at-risk populations in Fresno County by reducing the chance of preventable infection/illness through immunization. ♦ SMART Aim: By December 31, 2022, increase the percentage of children turning 2 years of age during the intervention period who are assigned to the targeted FQHC who have received the recommended vaccines by their second birthday. ♦ The first PIP intervention was a texting campaign to engage and remind parents of immunizations due. This intervention has provided slow, steady results since its implementation in September 2021. ♦ A second intervention was implemented in April 2022 called the Heroes for Health Immunization Event. The targeted FQHC opened and staffed its children's clinic from

2020–21 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	9 a.m. to 1 p.m. on a Saturday in April 2022 to provide only immunizations and dental exams. Families were scheduled to attend, and many prizes were awarded to attendees. We had a good turnout, and additional events are planned for the fall when the flu vaccine becomes available. To address *Cervical Cancer Screening* measure rates and performance, a Cervical Cancer Screening PDSA cycle was implemented. The purpose of the PDSA cycle was to increase treatment choices and improve survival rates of CalViva members in Fresno County who are diagnosed with cervical cancer through early detection. ♦ CalViva medical management staff members collaborated with a high-volume, low-compliance provider in Fresno County to improve compliance rates for cervical cancer screening. The priority barrier that this PDSA cycle addressed was related to the fact that many patients in the targeted population have questions about cervical cancer screening and many patients have deferred care during the pandemic. It has become acceptable to defer care, so outreach and reeducation needs to occur to address these barriers. ♦ The multidisciplinary team initiated a member outreach effort using a script with an extensive frequently asked questions (FAQ) section with various responses related to issues a patient may have questions about related to Pap tests/human papillomavirus (HPV) screening, including COVID-19 precautions and transportation. The FAQ section helped the caller to be prepared to answer questions. The team worked to engage all women included in

2020–21 External Quality Review Recommendations Directed to CalViva	Self-Reported Actions Taken by CalViva during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	the targeted population with an emphasis on those who were difficult to reach (i.e., phone number disconnected, and instances for which the caller had to leave a voicemail message). ♦ This proved to be a very successful project with 125/249 Pap tests completed in a four-month period during PDSA cycle 2.

Assessment of CalViva's Self-Reported Actions

HSAG reviewed CalViva's self-reported actions in Table E.8 and determined that CalViva adequately addressed HSAG's recommendation from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. Regarding the findings from the 2020 A&I Medical Audit, CalViva described in detail the steps that the MCMC plan has taken to improve IHA and IHEBA compliance and noted that DHCS had approved the MCMC plan's documentation regarding the finding related to appointment availability and access standards. Additionally, CalViva reported taking the needed steps to ensure the MCMC plan's processes for identifying dual-eligible exclusions for the Medicaid population are complete for performance measure reporting.

The MCMC plan attributed the decline in rates from measurement year 2019 to measurement year 2020 and CalViva's performance being below the minimum performance levels in measurement year 2020 to a number of factors, including COVID-19. CalViva reported implementing member-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020, including:

- Conducted outreach to members with depression, diabetes, hypertension, and pediatric care gaps to offer help with scheduling appointments, provide member education, and link members to health plan benefits and community resources.
- Implemented member outreach and education strategies through:
  - PDSA cycles in collaboration with an FQHC in Fresno County to reengage non-compliant diabetic members to help them obtain controlled HbA1c levels and maintain these levels within a healthy range.
  - PDSA cycles to improve early detection of cervical cancer, resulting in increased treatment choices and survival rates.

- A PIP in collaboration with an FQHC, a women's breast imaging center, and a local community-based organization in Fresno County to improve breast cancer screening completion rates.
- A PIP to improve the health and safety of the MCMC plan's youngest children and other at-risk populations in Fresno County by reducing the chance of preventable infection or illness through immunizations.

The strategies CalViva implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for CalViva" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for CalViva

Based on the overall assessment of CalViva's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- In response to the CAP from the 2020 A&I Medical Audit, CalViva provided documentation to DHCS regarding changes the MCMC plan made related to the findings A&I identified in the Case Management and Coordination of Care, Access and Availability of Care, Quality Management, and State Supported Services categories. CalViva made changes related to policies and procedures, training, and monitoring and oversight. Upon review of CalViva's documentation, DHCS closed the CAP.
- During the 2022 Medical and State Supported Services Audits of CalViva, A&I identified no findings in the Utilization Management, Member's Rights, Quality Management, Administrative and Organizational Capacity, and State Supported Services categories.
- The HSAG auditor determined that CalViva followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- CalViva performed above the high performance levels for the following measures in measurement year 2021:
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* for Kings County
  - *Controlling High Blood Pressure—Total* for Madera County
  - *Prenatal and Postpartum Care—Postpartum Care* for Kings County
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* for Kings and Madera counties
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* for Kings County

- CalViva's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Breast Cancer Screening—Total* for Kings County
  - *Cervical Cancer Screening* for Fresno County
  - *Chlamydia Screening in Women—Total* Fresno and Madera counties
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* for Fresno and Madera counties
  - Both *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* and *Counseling for Nutrition—Total* measures for Fresno County
- Across all reporting units for measure rates that HSAG compared to benchmarks in measurement year 2021, CalViva performed the best in Madera County based on the MCMC plan performing above the minimum performance levels for all rates and above the high performance levels for two of those rates for this reporting unit.
- For both the *Breast Cancer Screening Among Hmong-Speaking Members* Health Equity and *Childhood Immunizations* PIPs, CalViva met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- CalViva submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2022 Medical Audit of CalViva, A&I identified findings in the Case Management and Coordination of Care and Access and Availability of Care categories.
- Across all reporting units in measurement year 2021, CalViva performed below the minimum performance levels for the following eight of 45 measure rates that HSAG compared to benchmarks (18 percent):
  - *Breast Cancer Screening—Total* for Fresno County
  - *Child and Adolescent Well-Care Visits—Total* for Kings County
  - *Childhood Immunization Status—Combination 10* for Fresno and Kings counties
  - *Immunizations for Adolescents—Combination 2* for Kings County
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* for Fresno County
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* for Fresno and Kings counties

2021–22 External Quality Review Recommendations

- Address the findings from the 2022 A&I Medical Audit of CalViva by implementing the actions recommended by A&I.
- For measures for which CalViva performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, CalViva should determine whether the provider-focused interventions described in Table E.8 need to be revised or abandoned based on intervention evaluation results.

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

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

CenCal Health

Follow-Up on Prior Year Recommendations

Table E.9 provides EQR recommendations from CenCal's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.9 to preserve the accuracy of CenCal's self-reported actions.

Table E.9—CenCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For measures with rates below the minimum performance levels in measurement year 2020 or for which CenCal's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	For measures with rates below the minimum performance levels in measurement year 2020, CenCal assessed a number of factors as contributors to low performance, including: ♦ COVID-19 impacts. ♦ Members' lack of knowledge regarding preventive care. ♦ Members' reduced access to preventive care due to COVID-19 impacts on providers. ♦ Members prioritizing stay-at-home orders and postponing preventive care visits. CenCal completed interventions targeting the following measures through various quality improvement programs: ♦ *Controlling High Blood Pressure—Total* ■ An outreach program was developed to target members with high blood pressure to encourage them to visit their PCPs and promote the home blood pressure monitor benefit. CenCal also conducted a drug utilization review for members with hypertension who had not filled their hypertension control medications in the previous four

2020–21 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	months. For measurement year 2021, CenCal met the established minimum performance level for this measure. ♦ Both *Antidepressant Medication Management* measures ■ To improve antidepressant medication management, a toolkit for providers was developed focusing on adolescents. It included depression screening tips for providers, parent-facing health promotion materials, and adolescent-facing health promotion materials. CenCal also developed a website specifically for teens/adolescents. ■ Antidepressant medication management is included in CenCal's recently launched (March 2022) and newly integrated pay-for-performance (P4P) program, referred to as the Quality Care Incentive Program. This P4P program aligns financial incentives to health care providers with excellence in clinical care for CenCal members. Prior to the start of the program, PCPs received monthly gaps-in-care reports to improve this aspect of care throughout 2021. Through the Quality Care Incentive Program, providers continue to receive monthly performance reports and gaps-in-care data to support PCPs achieving excellence. ♦ *Chlamydia Screening in Women—Total* ■ To improve chlamydia screening in women, CenCal developed a digital educational intervention to encourage members to discuss with their PCPs the importance of chlamydia screening as well as other sexually transmitted

2020–21 External Quality Review Recommendations Directed to CenCal	Self-Reported Actions Taken by CenCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	diseases (STDs) and HIV screening. In October 2021, CenCal began a partnership with a large FQHC in San Luis Obispo County to pilot test the program. Pilot testing will continue through September 2022 to determine if the program can be expanded to other PCP locations. ■ Chlamydia screening is included in CenCal's recently launched (March 2022) and newly integrated P4P program, referred to as the Quality Care Incentive Program. This P4P program aligns financial incentives to health care providers with excellence in clinical care for CenCal members. Prior to the start of the program, PCPs received monthly gaps-in-care reports to improve this aspect of care throughout 2021. Through the Quality Care Incentive Program, providers continue to receive monthly performance reports and gaps-in-care data to support PCPs achieving excellence.

Assessment of CenCal 's Self-Reported Actions

HSAG reviewed CenCal's self-reported actions in Table E.9 and determined that CenCal adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. CenCal summarized the factors contributing to the MCMC plan's performance below the minimum performance levels in measurement year 2020 and described interventions targeting improving CenCal's performance for four measures. Of the four measures on which CenCal focused its efforts, HSAG made no comparisons to benchmarks in measurement year 2020 for one of the measures (*Controlling High Blood Pressure—Total*), and DHCS did not hold MCMC plans accountable to meet minimum performance levels for the two *Antidepressant Medication Management* measures for measurement year 2021; therefore, HSAG can make no assessment of whether CenCal's quality improvement efforts may have impacted the MCMC plan's performance related to these three measures. To improve performance on the *Chlamydia Screening in Women—Total* measure, CenCal reported collaborating with an

FQHC in San Luis Obispo County to pilot a digital educational intervention to encourage women to discuss with their PCPs the importance of chlamydia screening. CenCal also added chlamydia screening to its P4P program.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for CenCal

Based on the overall assessment of CenCal's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- During the 2021 Medical and State Supported Services Audits of CenCal, A&I identified no findings in the Utilization Management and State Supported Services categories. Additionally, in response to the CAP from these audits, CenCal provided documentation to DHCS regarding changes the MCMC plan made related to policies and procedures, training, and monitoring and oversight to address the audit findings. Upon review of CenCal's documentation, DHCS closed the CAP.
- The HSAG auditor determined that CenCal followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- CenCal performed above the high performance levels for the following measures in measurement year 2021:
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* for both reporting units
  - *Immunizations for Adolescents—Combination 2* for Santa Barbara County
  - *Prenatal and Postpartum Care—Postpartum Care* for both reporting units
  - All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures for San Luis Obispo County
- For both the *Postpartum Care for Members Residing in San Luis Obispo County* Health Equity and *Well-Child Visits in the First 15 Months of Life* PIPs, CenCal met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- CenCal submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- CenCal performed below the minimum performance levels in measurement year 2021 for the following three of 30 measure rates that HSAG compared to benchmarks (10 percent):
  - *Chlamydia Screening in Women—Total* for San Luis Obispo County

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

2021–22 External Quality Review Recommendations

- Assess whether the member education and provider incentive strategies described in Table E.9 to improve chlamydia screening rates need to be revised or abandoned based on CenCal's performance for the *Chlamydia Screening in Women—Total* measure remaining below the minimum performance level in measurement year 2021 for San Luis Obispo County.
- For both reporting units, assess the factors, which may include COVID-19, that resulted in CenCal performing below the minimum performance level for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure in measurement year 2021 and implement quality improvement strategies that target the identified factors.

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

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

Central California Alliance for Health

Follow-Up on Prior Year Recommendations

Table E.10 provides EQR recommendations from CCAH's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.10 to preserve the accuracy of CCAH's self-reported actions.

Table E.10—CCAH's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For measures with rates below the minimum performance levels in measurement year 2020 or for which CCAH's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	The external quality review organization (EQRO) identified the Women's Health domain as a key area of improvement. In reflection of HSAG's finding, the following strategic efforts were made by CCAH to improve performance in the Women's Health domain: ♦ CCAH conducted and concluded all required PDSA cycle interventions, all of which met and surpassed the project goal. In addition, planning was held to develop and add the *Breast Cancer Screening—Total* measure to CCAH's care-based incentive for measurement year 2022. ♦ Nationwide statistics indicated that measures within the Women's Health domain were extremely impacted by COVID-19. On September 30, 2021, NCQA announced that as a result of COVID-19, it saw a statistically significant drop of 4.7 percentage points for the national Medicaid *Breast Cancer Screening—Total* measure rate in 2020; conversely, CCAH's Merced County rate declined by only 2.96 percentage points from measurement year 2019 to measurement year 2020. ♦ The rates for the *Chlamydia Screening in Women* measures dropped largely because

2020–21 External Quality Review Recommendations Directed to CCAH	Self-Reported Actions Taken by CCAH during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	of lack of access to health care providers and utilization of services, similar to the *Breast Cancer Screening—Total* measure. To address the downturn of this measure, portal reports of non-compliant members were made available to providers to increase screening events. The EQRO noted that performance decreased for four measures in Merced County and eight measures in Monterey/Santa Cruz counties. It was recommended that quality strategies be developed to address the rate drops, without specificity for how to execute improvement strategies amid the COVID-19 pandemic. ♦ Due to multiple COVID-19 restrictions, encounter volume dropped significantly, while the eligible population for measures did not. Clinic closures, clinic staffing issues, members avoiding primary care due to illness or fear of infection, and deferred visits were all COVID-19-related factors that affected the timeliness and quality of services provided to members. ♦ As an active response to COVID-19 challenges, CCAH launched its 2022–26 Strategic Plan. With an overarching priority that creates health equity and a person-centered delivery system, all efforts are presently underway to eliminate health disparities, achieve optimal health outcomes for children and youth, increase member access, improve behavioral health services, and improve the system of care for members with complex medical and social needs. CCAH's Strategic Plan is aligned with HSAG's recommendation of creating timely and quality services.

Assessment of CCAH's Self-Reported Actions

HSAG reviewed CCAH's self-reported actions in Table E.10 and determined that CCAH adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. CCAH identified challenges related to COVID-19 as the main factor affecting the MCMC plan's performance on measures. CCAH indicated that the MCMC plan focused its efforts on performance measures within the Woman's Health domain, including conducting PDSA cycles to improve breast cancer screening rates and making plans to add the *Breast Cancer Screening—Total* measure to CCAH's care-based incentive for measurement year 2022. Additionally, to improve chlamydia screening rates, CCAH made reports of non-compliant members available to providers to increase screening events. Finally, to address COVID-19 challenges, CCAH launched its 2022–26 Strategic Plan, which prioritizes creating health equity and a person-centered delivery system.

The strategies CCAH implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for CCAH" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for CCAH

Based on the overall assessment of CCAH's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- The HSAG auditor determined that CCAH followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- CCAH performed above the high performance levels for the following measures in measurement year 2021:
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* for Monterey/Santa Cruz counties
  - *Immunizations for Adolescents—Combination 2* for Monterey/Santa Cruz counties
  - *Prenatal and Postpartum Care—Postpartum Care* for both reporting units
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* for Merced County
  - All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures for Monterey/Santa Cruz counties
- CCAH's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Breast Cancer Screening—Total* for Monterey/Santa Cruz counties

    - *Chlamydia Screening in Women—Total* for Monterey/Santa Cruz counties
    - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* for Merced County
- For both the *Child and Adolescent Well-Care Visits Among Members Residing in Merced County* Health Equity and *Childhood Immunizations* PIPs, CCAH met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- CCAH submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- CCAH performed below the minimum performance levels in measurement year 2021 for the following nine of 30 measure rates that HSAG compared to benchmarks (30 percent):
    - For Merced County:
        - *Breast Cancer Screening—Total*
        - *Child and Adolescent Well-Care Visits—Total*
        - *Childhood Immunization Status—Combination 10*
        - *Chlamydia Screening in Women—Total*
        - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total*
        - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*
    - For both reporting units:
        - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*

2021–22 External Quality Review Recommendations

- For measures for which CCAH performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors.
    - As part of this assessment, CCAH should determine whether the member- and provider-focused strategies described in Table E.10 to improve breast cancer and chlamydia screening rates were implemented differently in Monterey/Santa Cruz counties than in Merced County based on CCAH's performance for the *Breast Cancer Screening—Total* and *Chlamydia Screening in Women—Total* measures improving in Monterey/Santa Cruz counties and remaining below the minimum performance levels in measurement year 2021 in Merced County.

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

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

Community Health Group Partnership Plan

Follow-Up on Prior Year Recommendations

Table E.11 provides EQR recommendations from CHG's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.11 to preserve the accuracy of CHG's self-reported actions.

Table E.11—CHG's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to CHG	Self-Reported Actions Taken by CHG during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For measures for which CHG's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	For measures for which CHG's performance declined significantly from measurement year 2019 to measurement year 2020, the primary factor affecting CHG's performance was the COVID-19 pandemic and California's shelter-in-place Executive Order N33-20 which went into effect on March 19, 2020, and was lifted on June 15, 2021. The shelter-in-place orders not only affected the rendering of non-emergent/non-urgent, routine care, they also affected the collection of records and data used to report HEDIS measure rates. During the first months following Executive Order N33-20, preventive care, screening, and testing were postponed, initially due to the shelter-in-place provisions. Later, as businesses were able to operate in between surges, barriers included members being fearful about going to their providers' offices or taking public transportation and providers' offices having reduced appointment slots to accommodate members due to social distancing, COVID-19 safety protocols, and staffing. Additional challenges existed related to child care. Children were not physically in school, child care centers were not operating, and many provider offices were not allowing

2020–21 External Quality Review Recommendations Directed to CHG	Self-Reported Actions Taken by CHG during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	individuals other than the patient to attend the appointment. This left many members, particularly women, with fewer options to attend preventive visits. To mitigate the effects of the pandemic, CHG immediately promoted the use of telehealth visits as an alternative to in-person visits among providers as well as members. Telehealth provided access to services that did not require an in-person visit, such as cervical or breast cancer screening, immunizations, and lab tests such as HbA1c testing. CHG also implemented member and provider incentives that focused on getting a member in for an in-person visit. For example, an incentive program focused on immunizations and well-child visits was implemented in October 2021. Because telehealth visits count toward the required visits for the *Well-Child Visits in the First 30 Months of Life* measure but not for the *Childhood Immunization Status—Combination 10* measure, focusing on the *Childhood Immunization Status—Combination 10* measure positively affected both measures. CHG's strategy was and continues to be to work with PCPs to make the most of each vaccination visit by completing well-child exams when members are seen for vaccinations. Furthermore, due to the vaccination schedules and the HEDIS technical specifications, members are unable to catch up on some vaccinations, particularly the influenza vaccine, once time has elapsed. A member must have two influenza vaccines with different dates of service on or before the member's second birthday. CHG's historical data show that the influenza vaccination rate has been the lowest among the vaccinations

2020–21 External Quality Review Recommendations Directed to CHG	Self-Reported Actions Taken by CHG during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	included in the *Childhood Immunization Status—Combination 10* measure. Targeting the flu vaccine is important, especially during the pandemic, and doing so helped to close the gap on the *Well-Child Visits in the First 30 Months of Life* and *Childhood Immunization Status—Combination 10* measures.

Assessment of CHG's Self-Reported Actions

HSAG reviewed CHG's self-reported actions in Table E.11 and determined that CHG adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. CHG attributed the MCMC plan's decline in performance from measurement year 2019 to measurement year 2020 to COVID-19 and California's shelter-in-place orders that went into effect on March 19, 2020, and were in place until June 15, 2021.

To mitigate the effects of the pandemic, CHG indicated that the MCMC plan promoted among providers and members the use of telehealth visits as an alternative to in-person visits. CHG also reported that the MCMC plan implemented member and provider incentives that were focused on getting members to attend in-person visits once the State lifted the shelter-in-place orders.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for CHG

Based on the overall assessment of CHG's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- During the 2021 Medical and State Supported Services Audits of CHG, A&I identified no findings in the Utilization Management, Member's Rights, and Administrative and Organizational Capacity categories. Additionally, in response to the CAP from this audit, CHG provided documentation to DHCS regarding changes the MCMC plan made related to the findings A&I identified in the Case Management and Coordination of Care, Access and Availability of Care, Quality Management, and State Supported Services categories. CHG made changes related to policies and procedures, training, and monitoring and oversight. Upon review of CHG's documentation, DHCS closed the CAP.

- The HSAG auditor determined that CHG followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- CHG performed above the high performance levels in measurement year 2021 for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures.
- For both the *Cervical Cancer Screening Among Black/African-American Members* Health Equity and *Adolescent Well-Care Visits (Ages 12 to 17)* PIPs, CHG met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- CHG submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- CHG performed below the minimum performance levels in measurement year 2021 for both *Well-Child Visits in the First 30 Months of Life* measures.

2021–22 External Quality Review Recommendations

- For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in CHG performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors.

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

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

Contra Costa Health Plan

Follow-Up on Prior Year Recommendations

Table E.12 provides EQR recommendations from CCHP's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.12 to preserve the accuracy of CCHP's self-reported actions.

Table E.12—CCHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. Address the findings from the 2020 A&I Medical Audit by implementing the actions recommended by A&I, paying particular attention the repeat findings in the Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management categories.	CCHP has designed a monthly auditing program for all areas of clinical operations to include utilization management and case management. This auditing program will ensure that our members are getting services in accordance with our DHCS contract. Our operating model has changed to ensure that we have strong oversight on areas identified in the 2020 audit. Following are some specific areas we have improved. Case Management 2.1.7: CCHP's quality department developed a process for improved data capture of IHA completion, a monthly reporting mechanism to track IHA completion by provider, monthly member gap-in-care lists sent to providers, Quality Council reporting schedule on IHA completion rates and improvement strategies, and quarterly internal audits to ensure completion of all IHA elements. Provider and member education were developed for inclusion in provider and member newsletters and provider onboarding and quarterly trainings.

2020–21 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
2. To ensure CCHP accurately excludes enrollment spans, update the MCMC plan's exclusion methodology to rely on its HEDIS calculation engine (i.e., Cotiviti Quality Intelligence) to determine inclusion and exclusion criteria instead of during pre-processing steps.	During measurement year 2021, CCHP worked with Cotiviti to update the exclusion process. Cotiviti indicated that CCHP would need to develop the logic for dual eligible month calculations. As this required development and testing, CCHP's HSAG auditor approved the use of prior year processes. This involved exclusion of members with two or more months of dual coverage at any point in the measurement year and inclusion of members with a single month of dual coverage in files loaded into the Cotiviti engine. The CCHP business intelligence unit is currently developing a monthly exclusion algorithm. CCHP has updated our contract with Cotiviti to include a higher level of service and will ensure this change takes place in measurement year 2022.
3. For measures with rates below the minimum performance levels in measurement year 2020 or for which CCHP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	CCHP's chief medical officer has strengthened the relationship with PCPs to ensure that during provider trainings PCPs are made aware of the requirements for IHA completion within 120 days as well as involving providers in the health risk assessments and the Health Information Form/Member Evaluation Tool. Additionally, we have started to work with public health and strengthened the requirements of the memorandum of understanding by having meetings to ensure these members are being touched via the public health programs such as Child Health and Disability Prevention; immunizations; or the Women, Infants, and Children programs. Additionally, we have connected our facility site review nurses to these programs so that when visiting PCPs, they can share these various county programs that will help members access timely care.

2020–21 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	CCHP's chief executive officer and chief medical officer have hosted several meetings with John Muir Health Delivery System to strategize on how best to impact access to care and preventive care to keep our members out of the emergency room. **Rates with Significant Declines:** *Breast Cancer Screening—Total*—CCHP attributes the decline in performance to COVID-19. While our rate remained stable from measurement year 2020 to measurement year 2021, the rate improved from the 33rd to the 66th percentile, indicating a drop in rates across the nation. Strategies have included partnering with high-volume, low-performing clinics to outreach to overdue members. *Chlamydia Screening in Women—Total*—CCHP attributes the decline in performance to COVID-19. While our rate remained stable from measurement year 2020 to measurement year 2021, the rate improved from the 50th to the 75th percentile, indicating a drop in rates across the nation. *Contraceptive Care*—CCHP attributes the decline in performance to COVID-19. The rate remained stable from measurement year 2020 to measurement year 2021. *Developmental Screening in the First Three Years of Life—Total*—CCHP identified coding differences at our largest pediatric provider network that is assigned more than 50 percent of CCHP's membership. Our claims staff members have worked to improve the coding

2020–21 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	alignment to better capture screenings. In measurement year 2021, CCHP's total rate improved more than 15 percentage points. *Immunizations for Adolescents—Combination 2*—CCHP attributes the decline in performance to COVID-19. In measurement year 2021, CCHP's rates increased by more than 4 percentage points, keeping us in the 75th percentile. Strategies for improvement have included working with the Contra Costa Regional Medical Center 11 FQHCs network quality improvement plan (QIP) teams to develop outreach to youth with gaps in care, including immunization needs. In addition, CCHP expanded these types of strategies to our community provider network, which includes four FQHCs and individual providers. *Screening for Depression and Follow-Up Plan*—CCHP attributes the decline in performance to data integration issues. CCHP's quality department investigated whether there was an issue with capturing pharmacy data as a cause for lack of follow-up documentation. Findings show there likely was no issue with pharmacy data. CCHP's quality department worked with the Contra Costa Regional Medical Center network QIP team to create discrete data feeds for depression screening and follow-up. Internal monitoring showed that Contra Costa Regional Medical Center QIP data show marked improvement in depression screening and follow-up thus far in measurement year 2022. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI)*

2020–21 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Percentile Documentation—Total—CCHP identified coding differences at our largest pediatric provider network and worked to improve the coding alignment to better capture screenings. In measurement year 2021, CCHP's total rate improved by more than 5 percentage points, raising our percentile ranking to the 90th percentile. **Rates Below the Minimum Performance Levels:** *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*—CCHP attributes the decline in performance and rate being below the minimum performance level to COVID-19. CCHP developed and strengthened the Diabetes Case Management program, outreaching to members with HbA1c levels over 9.0 percent and providing them with remote glucometers and case management services. This was expanded to provide vendor case management to members with HbA1c levels between 9.0 and 11.0 percent and CCHP case management for members with HbA1c levels over 11.0 percent. In measurement year 2021, CCHP saw a decline in poor control of more than 4 percentage points and a move to the 75th percentile. *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*—CCHP attributes the rate being below the minimum performance level to COVID-19 and provider education issues. CCHP created a provider tip sheet and sent providers gaps-in-care lists along with the tip sheets to encourage

2020–21 External Quality Review Recommendations Directed to CCHP	Self-Reported Actions Taken by CCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	providers to ensure their patients get diabetes screenings. The Enhanced Care Management (ECM) Program is allowing CCHP to interface more with those members who go to the emergency room for care by connecting them to the ECM Program case managers who are working closely with the PCPs to ensure members access preventive care through their PCP. Currently, we have more than 4,000 members in the ECM Program, and high usage of the emergency room is considered so that we can link members to their PCPs. We are in the process of developing outcome metrics so we can ensure members are accessing care though the gatekeeper model versus not having an IHA and going to the emergency room. Going forward, CCHP is contracting with community health workers who will serve as ambassadors in reaching out to members to ensure they go to their PCP appointments and access the delivery system. We have signed a vendor agreement with a local provider and expanded the contract to the FQHCs in the Contra Costa Regional Medical Center and the community provider network.

Assessment of CCHP's Self-Reported Actions

HSAG reviewed CCHP's self-reported actions in Table E.12 and determined that CCHP adequately addressed HSAG's recommendation from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. CCHP summarized the steps the MCMC plan has taken to resolve the findings from the 2020 A&I Medical Audit. Additionally, CCHP reported taking the needed actions with its vendor to ensure the MCMC plan accurately excludes enrollment spans for performance measure reporting.

CCHP primarily attributed the MCMC plan's performance below the minimum performance levels in measurement year 2021 and decline in performance from measurement year 2019 to measurement year 2020 to COVID-19 challenges. CCHP reported implementing member- and provider-focused interventions to improve the MCMC plan's performance on measures, including:

- Partnered with high-volume, low-performing clinics to outreach to members due for services.
- Worked to improve the coding issues identified at the MCMC plan's largest pediatric provider network to better capture screenings.
- Partnered with multiple clinics to develop outreach to youth with gaps in care, including immunizations.
- Developed and strengthened the MCMC plan's Diabetes Case Management Program, including outreaching to members with HbA1c levels over 9.0 percent and providing them with remote glucometers and case management services.
- Created a tip sheet and sent providers gaps-in-care lists along with the tip sheet to encourage providers to discuss with diabetic patients the importance of getting their diabetes screenings.

The strategies CCHP implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for CCHP" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for CCHP

Based on the overall assessment of CCHP's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- During the 2021 Medical and State Supported Services Audits of CCHP, A&I identified no findings in the Administrative and Organizational Capacity category.
- The HSAG auditor determined that CCHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- CCHP performed above the high performance levels for the following measures in measurement year 2021:
  - *Cervical Cancer Screening*
  - Both *Prenatal and Postpartum Care* measures
  - All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures

- CCHP's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Breast Cancer Screening—Total*
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
- For both the *Diabetes Control Among Members Residing in Specific Regions of Contra Costa County* Health Equity and *Well-Child Visits (Ages 3 to 6)* PIPs, CCHP met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- CCHP submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2021 Medical and State Supported Services Audits of CCHP, A&I identified findings in all but one category and noted repeat findings in the Member's Rights and Quality Management categories.
- CCHP's CAP from the 2020 A&I Medical Audit remains open as of the production of this report.
- CCHP performed below the minimum performance levels in measurement year 2021 for both *Well-Child Visits in the First 30 Months of Life* measures.

2021–22 External Quality Review Recommendations

- Continue to work with DHCS to fully resolve all findings from the 2020 A&I Medical Audit of CCHP.
- Address the findings from the 2021 A&I Medical and State Supported Services Audits of CCHP by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Member's Rights and Quality Management categories.
- For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in CCHP performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors.

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

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

Family Mosaic Project

Follow-Up on Prior Year Recommendations

DHCS provided each MCMC plan an opportunity to outline actions taken to address recommendations HSAG made in its 2020–21 MCMC plan-specific evaluation report. Based on HSAG's assessment of FMP's delivery of quality, accessible, and timely care through the activities described in the MCMC plan's 2020–21 MCMC plan-specific evaluation report, HSAG included no recommendations in FMP's 2020–21 MCMC plan-specific evaluation report. Therefore, FMP had no recommendations for which it was required to provide the MCMC plan's self-reported actions.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for FMP

Based on the overall assessment of FMP's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- ♦ The HSAG auditor determined that FMP followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- ♦ For both the *Improving Family Functioning* and *Reducing Anxiety Symptoms* PIPs, FMP met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.

Opportunities for Improvement

- ♦ HSAG identified no opportunities for improvement for FMP.

2021–22 External Quality Review Recommendations

Based on DHCS informing HSAG that FMP is to no longer be included in EQR activities as of May 2022, HSAG makes no recommendations to the MCMC plan.

Gold Coast Health Plan

Follow-Up on Prior Year Recommendations

Table E.13 provides EQR recommendations from GCHP's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.13 to preserve the accuracy of GCHP's self-reported actions.

Table E.13—GCHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For measures with rates below the minimum performance levels in measurement year 2020 or for which GCHP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	Based on GCHP's assessment of measures with rates that declined from measurement year 2019 to measurement year 2020 or that were below the minimum performance levels in measurement year 2020, GCHP noted improvement from measurement year 2020 to measurement year 2021 for all measures except the *Breast Cancer Screening—Total* measure. The following improvement strategies were developed in 2021–22 to improve these rates. ***Antidepressant Medication Management*** Intervention Strategy: COVID-19 QIP Domain 1: Behavioral Health Domain ♦ Strategy: Improve antidepressant medication adherence for the Hispanic/Latino population residing in Area 5 (Oxnard, Port Hueneme, Point Mugu) through improved primary care/clinic behavioral health integration (BHI). ♦ Observation: Providing BHI in primary care is an effective strategy for increasing medication adherence.

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ Next steps: Continue BHI pilot with provider systems and share learning among larger provider network system. Intervention Strategy: Engage in partnerships with internal departments and external organizations, (e.g., Community Relations Department, Beacon Health Options) to promote best practices and increase awareness. ♦ Beacon Health Options: Reviewed and approved the annual Beacon Health member surveys. ♦ Strengthening Families: Participated in the Strengthening Families monthly meetings, which included a presentation by the National Alliance on Mental Illness Ventura County in support of Mental Health Awareness Month. ♦ Incorporated the National Alliance on Mental Illness into Adverse Childhood Experiences Network of Care to promote behavioral health and well-being among our members, May 2021. Intervention Strategy: Support implementation of BHI programs for Ventura County through Proposition 56 funding to incentivize MCMC plans to promote BHI in their provider networks. ♦ Hosted regular BHI provider convenings to provide technical assistance for the grant and topics relevant to BHI. ♦ Facilitated monthly check-in meetings with providers to review status of the program and problem-solve any barriers to milestone achievement.

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ Reviewed and provided feedback on quarterly progress reports. ♦ Executed data sharing agreement with Ventura County Behavioral Health Department to facilitate performance measure reporting. ♦ Investigated measures with rates of zero, rectified identified issues, and reported baseline rates for 2021. ♦ Reported annual performance measures for 2021 (measures with a baseline rate in 2020). Intervention Strategy: Provider articles published regarding this topic included: ♦ *Behavior Health Services—Caring through COVID-19*, June 2021. ♦ *Don't Delay Care: Return to Care after Pandemic & Assistance with Scheduling Appointments*, September 2021, Building Community. ♦ *Increasing Preventive Screenings & Return to Care (MI)*, February 2022, Provider Operations Bulletin. Intervention Strategy: Data improvement ♦ Evaluated and updated data mapping and data table development to improve accuracy of reporting behavioral health measures. Intervention Strategy: Provider education materials ♦ Provide clinics/providers with the annual measurement year 2020 MCAS/HEDIS rate report.

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ Provide access to the INDICES Provider Insights Dashboards to view their performance on MCAS measures, including member- and clinic-level data for monitoring current and projected measure performance, trending, and gap analysis. ♦ Update and post the MCAS FAQs, reference materials, and tip sheets with the current measure specifications. ♦ Provide clinics/providers with a behavioral health-themed MCAS rate and member gap report (to align with National Mental Health Week October 2021). ***Asthma Medication Ratio*** Intervention Strategy: COVID-19 QIP Domain 2: Chronic Disease Domain ♦ Strategy: Enrolled members in the CDSMP to improve self-management of chronic diseases, including management of medications. ♦ Member Feedback: The workshops motivated members to engage in a healthy lifestyle by increasing activity and selecting healthier foods. ♦ Next Steps: GCHP's Health Education/Cultural Linguistics Department will continue to promote and offer the CDSMP workshops. Intervention Strategy: Asthma exam outreach and member incentive pilot project with clinic partners ♦ Strategy: Used a cascade-of-care model to integrate member and provider interventions focused on improving asthma management across the continuum of care that utilized a health plan/clinic-coordinated

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	intervention to promote the same message: (1) schedule an asthma exam, (2) complete and/or update an asthma action plan, and (3) assess current asthma medication regimen. The clinics participating in the outreach program received GCHP-developed outreach tools and the GCHP asthma exam incentive forms to contact members and promote the importance of the asthma management incentive program and schedule office or telehealth appointments. The incentive program awarded members with a $40 gift card if the provider completes the following three components during the clinic visits: asthma exam, new/updated asthma action plan, and asthma medication assessment. ♦ Outcome Analysis: ▪ We predicted that the outreach program would increase asthma exams. ▪ The goal was to schedule asthma exams for 50 percent of the GCHP members contacted through the GCHP-Ventura County Medical Center asthma outreach collaborative. ▪ The combined asthma exam scheduling rate for all three clinics was 38 percent. While two clinics were able to schedule exams for more than 50 percent of the members contacted, one clinic was unable to schedule any exams because some members were unavailable during available appointment times. ▪ Overall outcome assessment: The member incentive was effective. The member incentive program proved to engage providers to complete all three components of an asthma exam and to

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	engage members in scheduling the appointments. ♦ Next steps: Expand the member incentive to all members diagnosed with asthma. Intervention Strategy: Incentive Programs ♦ Asthma Exam Member Incentive Program Strategy: The Asthma Exam Member Incentive Program targets full-scope Medi-Cal members between 5 and 64 years of age who are diagnosed with asthma and have a greater than 50 percent ratio of asthma medication to total asthma medications. The goal of the incentive is to promote, educate, and engage members to complete their annual asthma exams and to alert both the members and their providers to complete three assessments during an office or telehealth visit: the asthma exam, create or update an asthma action plan, and review asthma medication. The member incentive program consists of rewarding a member with a $40.00 gift card if the member completes all three components during an office or telehealth visit. The member incentive program will be promoted to both members and providers through various campaigns via member mailers, the GCHP website, member and provider publications, community collaboratives, and outreach programs. ♦ Provider Incentive Program: To increase asthma exams and medication management, a new provider incentive program was launched in 2022 to provide quarterly awards to providers who submit the highest number of member incentives including the asthma-focused member incentive.

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Intervention Strategy: Provider newsletter articles published regarding this topic included: ♦ *Health Education Resources: Chronic Disease Self-Management Programs*, July 2021, Provider Operations Bulletin. ♦ *New Asthma Member Incentive Program*, July 2021, Provider Operations Bulletin. ♦ *Provider Asthma Packets: Member Incentive and Asthma Action Plan*, November 2021, Provider Operations Bulletin. ♦ *Don't Delay Care: Return to Care after Pandemic & Assistance with Scheduling Appointments*, September 2021, Building Community. ♦ *Increasing Preventive Screenings & Return to Care (MI)*, February 2022, Provider Operations Bulletin. Intervention Strategy: Provider education materials ♦ Provide clinics/providers with the annual MY 2020 MCAS/HEDIS rate report. ♦ Provide access to the INDICES Provider Insights Dashboards to view their performance on MCAS measures, including member- and clinic-level data for monitoring current and projected measure performance, trending, and gap analysis. ♦ Update and post the MCAS FAQs, reference materials, and tip sheets with the current measure specifications. Intervention Strategy: Quarterly quality improvement collaborations with clinic systems.

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ Presentation regarding launch of clinic incentive programs to promote utilization of member incentives. ***Breast Cancer Screening, Cervical Cancer Screening, and Chlamydia Screening in Women*** Intervention Strategy: Women's Health SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis: October 1, 2021, through May 25, 2022. Increase cervical cancer screenings member incentives strategy. ♦ Action Plans: ■ Deliver member incentives at the point-of-care. ■ Conduct follow-up calls regarding invalid member incentives. ■ Share clinic packets during facility site reviews. ■ Implement quarterly provider incentive program for member incentive submissions. Address provider barriers for breast cancer, cervical cancer, and chlamydia screenings strategy. ♦ Action Plans ■ Clinics pair age-appropriate women's health screenings. ■ GCHP-Ventura County Medical Center co-branded mammogram postcard. ■ Conduct in-person/virtual provider training on chlamydia screening best practice guidelines. ■ Address health disparities caused by cultural and linguistic barriers.

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Address member barriers for breast cancer, cervical cancer, and chlamydia screenings. ♦ Action Plans ■ Create women's health educational materials. ■ Address health disparities caused by cultural and linguistic barriers. ■ Collaborate with Every Woman Counts Program on women's health education programs. ■ Collaborate with GCHP's community relations staff members to promote women's health screenings at community events. Intervention Strategy: Incentive programs ♦ Cervical Cancer Screening Member Incentive Program: This member incentive program aims to incentivize women ages 21 to 64 years of age to complete their routine cervical cancer screenings by providing them with a $25 gift card for completing the exam. The incentive intends to help break down barriers such as transportation, access, education, and fear of the exam itself. The member incentive program was promoted to both members and providers through various campaigns via member mailers, the GCHP website, member and provider publications, community collaboratives, and outreach programs. ♦ Provider Incentive Program: To increase cervical cancer screenings, a new provider incentive program was launched in 2022 to provide quarterly awards to providers who submit the highest number of member

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	incentives, including those for cervical cancer screenings. Intervention Strategy: Provider newsletters. Articles published regarding this topic included: ♦ *Updated Imaging Centers for Mammograms*, July 2021, GCHP website. ♦ *Health Education Resources: BCS, CCS and HPV Screenings*, July 2021, Provider Operations Bulletin. ♦ *Don't Delay Care: Return to Care After Pandemic & Assistance with Scheduling Appointments*, September 2021, Building Community. ♦ *Increasing Preventive Screenings & Return to Care (MI)*, February 2022, Provider Operations Bulletin. Intervention Strategy: Provider education materials ♦ Provide clinics/providers with the annual measurement year 2020 MCAS/HEDIS rate report. ♦ Provide access to the INDICES Provider Insights Dashboards to view their performance on MCAS measures, including member and clinic level data for monitoring current and projected measure performance, trending, and gap analysis. ♦ Provide clinics/providers with women's health-themed MCAS rate and member gap reports: ▪ The chlamydia and cervical cancer screening member gap reports were distributed to providers for Sexually Transmitted Infection (STI)/STD Awareness Month.

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	■ The breast cancer screening gap report was distributed to providers for Breast Cancer Awareness Month. ♦ Update and post the MCAS FAQs, reference materials, and tip sheets with the current measure specifications. Intervention Strategy: Quarterly quality improvement collaborations with clinic systems. Best practice sharing on cervical cancer screening presentation by Ventura County Health Care Agency, February 2022. ***Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)*** Intervention Strategy: PDSA Cycle 1: September 1, 2021, through December 31, 2021 ♦ Intervention: CDSMP with $25 gift card ♦ Target population: 208 members 21 to 39 years of age with HbA1c >9.0 living in Oxnard, Port Hueneme, and Point Mugu ♦ Successes ■ The measure rate for the target population declined 11.44 percentage points from 61.90 percent to 50.46 percent (a lower rate is better). ■ Two additional CDSMP classes were added. ■ Members indicated that the health education was valuable. ♦ Barriers ■ Challenges with retaining enrollment during the holidays.

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	■ Members unavailable to attend daytime CDSMP workshops. ■ Some members did not have devices/tools to join virtual classes. Intervention Strategy: PDSA Cycle 2: February 1, 2022, through May 25, 2022 ♦ Intervention: CDSMP with $25 gift card. ♦ Target population: 82 members 18 years of age and older with HbA1c >9.0 living in Santa Paula who are assigned to three Ventura County Medical Center clinics. ♦ Successes: ■ The measure rate for the target population declined 11.95 percentage points from 41.84 percent to 29.89 percent (a lower rate is better). ■ Fifty-seven percent of the members who enrolled completed all six sessions. ■ Positive member feedback. “The class assisted me in finding ways to manage my condition and it helped me take responsibility for my health.” Member stated, “The facilitator was very encouraging.” ♦ Barriers: ■ Challenges connecting with members during telephone outreach. Only 36 percent of the members outreached were successfully contacted to promote the CSDMP classes. ■ Scheduling conflicts: 25 percent of the members spoken to were interested in the classes but could not attend due to scheduling conflicts.

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Intervention Strategy: COVID-19 QIP Domain 2: Chronic Disease Domain ♦ Strategy: Enroll members in CDSMP to improve self-management of chronic diseases. ♦ Outcomes: GCHP received positive member feedback. The workshops motivated members to engage in a healthy lifestyle by increasing activity, selecting healthier foods, and monitoring their blood glucose. ♦ Next Steps: GCHP's Health Education/Cultural Linguistics Department will continue to promote and offer the CDSMP workshops. Intervention Strategy: Development of the Diabetes Member Incentive Program ♦ This is a new member incentive that is in development and expected to launch in 2022. ♦ The goal of this member incentive program will be to reward members with up to two gift cards: one gift card for completing an HbA1c test and one gift card for maintaining an HbA1c level of <8.0. Intervention Strategy: Provider newsletters Articles published regarding this topic included: ♦ *Health Education Resources: My Diabetes Record Exam*, July 2021, Provider Operations Bulletin. ♦ "*My Diabetes Exam Record*" flyer for members, November 2021, Provider Operations Bulletin. ♦ *Don't Delay Care: Return to Care after Pandemic & Assistance with Scheduling*

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Appointments, September 2021, Building Community. ♦ *Increasing Preventive Screenings & Return to Care (MI)*, February 2022, Provider Operations Bulletin. Intervention Strategy: Provider education materials ♦ Provide clinics/providers with the annual measurement year 2020 MCAS/HEDIS rate report. ♦ Provide access to the INDICES Provider Insights Dashboards to view their performance on MCAS measures, including member- and clinic-level data for monitoring current and projected measure performance, trending, and gap analysis. Update and post the MCAS FAQs, reference materials, and tip sheets with the current measure specifications. ***Controlling High Blood Pressure*** Intervention Strategy: Promote blood pressure cuff member benefit to increase home blood pressure monitoring Intervention Strategy: COVID-19 QIP Domain 2: Chronic Disease Domain ♦ Strategy: Enroll members in CDSMP to improve self-management of chronic diseases. ♦ Member Feedback: The workshops motivated members to engage in a healthy lifestyle by increasing activity, selecting healthier foods, and monitoring their blood pressure.

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ Next Steps: GCHP's Health Education/Cultural Linguistics Department will continue to promote and offer the CDSMP workshops. Intervention Strategy: Provider newsletter articles published regarding this topic included: ♦ *Health Education Resources: Hypertension*, June 2021, Provider Operations Bulletin. ♦ *Blood Pressure Cuff Covered Benefit,* November 2021, Provider Operations Bulletin. ♦ *My Blood Pressure Check-Up* flyer for members, February 2022, Provider Operations Bulletin. ♦ *Don't Delay Care: Return to Care after Pandemic & Assistance with Scheduling Appointments*, September 2021, Building Community. ♦ *Increasing Preventive Screenings & Return to Care (MI)*, February 2022, Provider Operations Bulletin Intervention Strategy: Provider measure education materials ♦ Provide clinics/providers with the annual measurement year 2020 MCAS/HEDIS rate report. ♦ Provide access to the INDICES Provider Insights Dashboards to view their performance on MCAS measures, including member- and clinic-level data for monitoring current and projected measure performance, trending, and gap analysis.

2020–21 External Quality Review Recommendations Directed to GCHP	Self-Reported Actions Taken by GCHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ Update and post the MCAS FAQs, reference materials, and tip sheets with the current measure specifications. Intervention Strategy: Quarterly quality improvement collaborations with clinic systems ♦ Best practices pilot program for home blood pressure monitoring presented by the Ventura County Health Care Agency, February 2022.

Assessment of GCHP's Self-Reported Actions

HSAG reviewed GCHP's self-reported actions in Table E.13 and determined that GCHP adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. GCHP reported implementing member- and provider-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020, including:

- To increase awareness of behavioral health services and improve antidepressant medication adherence:
  - Piloted improved primary care BHI with a clinic in Area 5.
  - Engaged in internal and external partnerships to promote best practices and increase awareness.
  - Included articles about behavioral health services in various provider-focused publications.
- As part of the MCMC plan's COVID-19 QIP:
  - Implemented provider and member incentive programs.
  - Conducted member outreach.
  - To improve services provided to members with chronic diseases, included articles about chronic diseases in provider-focused publications.
  - Conducted provider education to increase member participation in CDSMP.
- Conducted a SWOT analysis to improve breast, cervical, and chlamydia screening rates, resulting in GCHP implementing action plans, including:
  - Delivering member incentives at the point-of-care.
  - Sharing clinic packets during facility site reviews.

  - Implementing provider incentives.
  - Conducting provider trainings.
  - Addressing health disparities caused by cultural and linguistic barriers.
  - Creating women's health educational materials.
  - Collaborating with women's health programs.
  - Including articles about women's health screenings in various provider-focused publications.
- Through PDSA cycles, tested providing a member incentive for participation in the CDSMP to improve HbA1c control in members with diabetes.

The strategies GCHP implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for GCHP" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for GCHP

Based on the overall assessment of GCHP's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- During the 2021 Medical and State Supported Services Audits of GCHP, A&I identified findings in only one category (Member's Rights). In response to the CAP from this audit, GCHP provided documentation to DHCS regarding changes the MCMC plan made related to the findings A&I identified in the Member's Rights category. GCHP made changes related to policies and procedures, frequency of grievance and appeals training, and call center monitoring and oversight processes. Upon review of GCHP's documentation, DHCS closed the CAP.
- The HSAG auditor determined that GCHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2021.
- GCHP performed above the high performance levels in measurement year 2021 for both *Prenatal and Postpartum Care* measures.
- GCHP's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Cervical Cancer Screening*
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
- For both the *Cervical Cancer Screening Among Members Residing in Area 5* Health Equity and *Adolescent Well-Care Visits (Ages 12 to 17)* PIPs, GCHP met all validation criteria for

modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.

- GCHP submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- While the impact on performance measure reporting was minimal, the HSAG auditor noted that some measurement year 2021 encounter data were missing from a vendor GCHP contracted with in October 2021 for a small percentage of the MCMC plan's membership.
- GHCP performed below the minimum performance levels in measurement year 2021 for the following five of 15 measure rates that HSAG compared to benchmarks (33 percent):
  - *Breast Cancer Screening—Total*
  - *Child and Adolescent Well-Care Visits—Total*
  - *Chlamydia Screening in Women—Total*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

2021–22 External Quality Review Recommendations

- Improve monitoring and oversight processes for the MCMC plan's encounter data to ensure that all encounter data are included for performance measure reporting.
- Assess whether the member- and provider-focused strategies described in Table E.13 to improve breast cancer and chlamydia screening rates need to be revised or abandoned based on GCHP's performance for the *Breast Cancer Screening—Total* and *Chlamydia Screening in Women—Total* measures remaining below the minimum performance levels in measurement year 2021.
- For the *Child and Adolescent Well-Care Visits—Total* and both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in GCHP performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors.

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

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

Health Net Community Solutions, Inc.

Follow-Up on Prior Year Recommendations

Table E.14 provides EQR recommendations from Health Net's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.14 to preserve the accuracy of Health Net's self-reported actions.

Table E.14—Health Net's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. Work with DHCS to ensure that Health Net fully resolves the findings from the 2021 Medical Audit in the Access and Availability of Care and Member's Rights categories. The MCMC plan should review the A&I's recommendations and develop and implement policies and procedures that address the identified findings.	The transportation vendor monitors enrollment status of our transportation network and provides monthly reporting to the MCMC plan. Health Net is exploring and initiating contracting efforts with other identified transportation providers in the area. The vendor's policy has been updated to require Medi-Cal enrollment prior to contracting with new transportation providers.
2. To ensure Health Net's processes for identifying dual-eligible exclusions for the Medicaid population are complete, update its exclusion methodology to meet the National Committee for Quality Assurance requirements to exclude dual-eligible Medicaid members with either (1) both Medicare Part A and Part B or (2) Medicare Part C coverage.	After consulting with our auditor and NCQA, it was determined that we should exclude full duals and Part B coverage. Medicare Part A coverage enrollment spans were added back into our Medi-Cal projects for measurement year 2021. Any removal of data is done at the enrollment span level (i.e., we only remove the span tied to full dual or Part B coverage). Members may ultimately still count toward certain measures.
3. For measures with rates below the minimum performance levels in measurement year 2020 or for which Health Net's performance declined significantly from measurement year 2019 to measurement year 2020,	For measures with rates below the minimum performance levels in measurement year 2020 or that declined significantly from measurement year 2019 to measurement year 2020, Health Net has implemented initiatives to address timeliness and quality of services

2020–21 External Quality Review Recommendations Directed to Health Net	Self-Reported Actions Taken by Health Net during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	provided to members as noted in the MCMC plan's Quality Work Plan. A few examples are listed below: ♦ Annual HEDIS Unit Family Outreach Initiative: Member outreach focused on live calls with an offer of a warm transfer to the member's PCP to schedule a visit to close care gaps for MCAS measures. ♦ Mobile Mammography: This program partners with providers/clinic sites to expand convenient access to breast cancer screenings via mobile mammography to address barriers to access to care. Equipment (via mobile unit or portable coach) and state licensed technicians are provided by contracted vendors to conduct the breast cancer screenings. ♦ One-Stop Clinics: One-stop clinics provide clinical care during extended clinic hours (hours outside of a provider's regular business hours or during a set block of time during the week dedicated to Health Net members), such as evenings and weekends, and can bring additional services on-site to address multiple care gaps at once. ♦ Member Engagement Incentive Program: Point-of-care gift card for members engaging with their providers and accessing care.

Assessment of Health Net's Self-Reported Actions

HSAG reviewed Health Net's self-reported actions in Table E.14 and determined that Health Net adequately addressed HSAG's recommendation from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. Health Net summarized the steps the MCMC plan has taken to address the findings from the 2021 A&I Medical Audit. Additionally, Health Net described the steps it took to ensure the MCMC plan's processes for identifying dual-eligible exclusions for the Medicaid population are complete for performance measure reporting. Finally, Health Net reported implementing initiatives to address the

timeliness and quality of services provided to its members and indicated that these initiatives are included in Health Net's Quality Work Plan. Health Net provided examples of the initiatives the MCMC plan implemented, including:

- Conducted live outreach calls to offer a warm transfer to members' PCPs to schedule an office visit.
- Partnered with providers to offer mobile mammography services.
- Offered one-stop clinics that operated outside of regular business days and hours.
- Implemented a member engagement incentive program that offered a gift card at the point-of-care.

The strategies Health Net implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Health Net" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Health Net

Based on the overall assessment of Health Net's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- While the CAP for the MCMC plan's 2021 A&I Medical Audit remains open as of the production of this report, Health Net's self-reported actions as summarized in Table E.14 demonstrate that the MCMC plan has taken actions to address all findings identified by A&I.
- During the 2022 Medical and State Supported Services Audits of Health Net, A&I identified no findings in the Quality Management, Administrative and Organizational Capacity, and State Supported Services categories.
- The HSAG auditor determined that Health Net followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- Across all reporting units for measure rates that HSAG compared to benchmarks in measurement year 2021, Health Net's performance:
  - Was above the high performance levels for the following measures:
    - *Chlamydia Screening in Women—Total* for Kern, Los Angeles, and Tulare counties
    - Both *Prenatal and Postpartum Care* measures in Tulare County
    - All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures in Sacramento County

        - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* in Los Angeles County
    - Moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021 for 14 rates.
    - Was highest in Tulare County based on Health Net performing above the high performance levels for three rates and performing below the minimum performance levels for only two rates for this reporting unit.
- For both the *Breast Cancer Screening Among Russian Members in Sacramento County* Health Equity and *Childhood Immunizations* PIPs, Health Net met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- Health Net submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- Health Net's CAP from the 2021 A&I Medical Audit remains open as of the production of this report.
- During the 2022 Medical Audit of Health Net, A&I identified findings in the Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, and Member's Rights categories. A&I identified repeat findings in the Access and Availability of Care and Member's Rights categories.
- Across all reporting units for measure rates that HSAG compared to benchmarks in measurement year 2021, Health Net's performance:
    - Was below the minimum performance levels for 58 of 105 rates (55 percent).
    - Was lowest in Stanislaus County based on Health Net performing below the minimum performance levels for 14 rates for this reporting unit.

2021–22 External Quality Review Recommendations

- Continue to work with DHCS to fully resolve all findings from the 2021 A&I Medical Audit of Health Net.
- Address the findings from the 2022 A&I Medical Audit of Health Net by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in in the Access and Availability of Care and Member's Rights categories.
- For measures for which Health Net performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Health Net should determine whether the initiatives described in Table E.14 need to be revised or abandoned based on intervention evaluation results.

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

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

Health Plan of San Joaquin

Follow-Up on Prior Year Recommendations

Table E.15 provides EQR recommendations from HPSJ's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.15 to preserve the accuracy of HPSJ's self-reported actions.

Table E.15—HPSJ's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For measures with rates below the minimum performance levels in measurement year 2020 or for which HPSJ's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	COVID-19 created new challenges and exacerbated existing ones when the shelter-in-place orders were given. One of the biggest issues was a new access problem, as mandatory infection control efforts and staffing challenges greatly reduced the availability of appointment times for primary care, specialty, and ancillary services. The network is still trying to recover, with many larger providers still quoting staffing issues, particularly medical providers (physicians and nurse practitioners/physician assistants), as a major barrier to care. Furthermore, many of the local labs are now requiring appointments to be scheduled, when prior to COVID-19 walk-ins were accepted, creating an additional barrier and deterrent for Medi-Cal members who may be turned away at the door for not having an appointment. The MCMC plan has redoubled efforts to encourage members to seek health care over the last year, using member newsletters, call campaigns, and additional outreach efforts to encourage members to see their PCP for preventive services. Additionally, the MCMC plan has also continued provider education

2020–21 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	efforts regarding the MCAS measures, as well as finding ways to partner with providers to remove barriers to care. For all MCAS measures, the MCMC plan has continued advocating for better data exchange from providers, whether through improved billing and coding or via supplemental data sources like EHR extracts, or leveraging the local health information exchange. These alternative data sources allow for MCMC plan receipt of data points like BMI values, point-of-care HbA1c test scores, and blood pressure results. Also, the MCMC plan has ongoing support for provider care gap clinics, including the start of direct scheduling and warm transfer efforts by our population health team in 2022. For providers who opt in for this, our population health team assists in getting members to care by outreaching to them and either directly scheduling them in the provider's scheduling system, or by providing a warm transfer via a three-way call to connect members to the scheduling team at the provider's office or call center. These interventions are ongoing and are being applied across several measures with the aim of assisting providers with some of the administrative burden of patient outreach, as well as addressing member barriers like transportation at the time of the call. Children's Health Measures—Impacted measure with significant decrease: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—*

2020–21 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Body Mass Index (BMI) Percentile Documentation—Total The MCMC plan has made a renewed focus on well-child visits and has been leveraging our Provider Partnership Program to discuss opportunities for collaboration (like the direct scheduling efforts for example) with our FQHCs as well as the other participating provider groups in the program. The rationale is that if children can be brought in for their wellness visit, most of the childhood measures will automatically fall into place due to the expected preventive services at each visit. This has been done in tandem with data efforts to ensure that certain things, like BMI percentiles, can be received by the MCMC plan from the providers when the service is rendered. Women's Health Measures—Impacted measures with significant decrease: ♦ *Breast Cancer Screening—Total* ♦ All three *Chlamydia Screening in Women* measures ♦ Both *Contraceptive Care—All Women—Most or Moderately Effective Contraception* measures ♦ *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—3 Days—Ages 21–44 Years* ♦ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* The MCMC plan has been working with our provider partnership participants to emphasize all women's health measures, especially if the

2020–21 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	provider also performs obstetric services or is affiliated with an obstetrician (OB)/gynecologist (GYN) group. Provider education regarding types of chlamydia screenings (i.e., urine screenings versus vaginal swab), exclusion code submission, and other relevant women's health information has been very helpful for the network, and some providers have already implemented the changes to increase their compliance. The MCMC plan has also reached out to several major OB/GYN groups in 2022 and provided some education on the MCAS measures to which they directly contribute (e.g., *Contraceptive Care*), and to understand barriers to care from their perspective. Acute/Chronic Disease Measures—Impacted measures with significant decrease: ♦ *Asthma Medication Ratio—Total* ♦ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* ♦ *Plan All-Cause Readmissions—Observed Readmissions—Total* The MCMC plan has continued efforts to increase compliance with labs through our ongoing Diabetic Management Program, as well as through the Provider Partnership Program, PDSA cycles with a health disparity focus, and data efforts. Two of the FQHCs in our network have opened diabetes clinics and have been working directly with our Diabetic Management Program to bolster education efforts and reduce barriers for diabetic members who are assigned to those FQHCs.

2020–21 External Quality Review Recommendations Directed to HPSJ	Self-Reported Actions Taken by HPSJ during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	The Medi-Cal Rx carve-out has created some unique challenges for the *Asthma Medication Ratio—Total* measure; however, the MCMC plan has continued efforts to encourage members who are asthmatic to be compliant with their medication regimens. Even though it is outside of the general inquiry window, starting July 1, 2022, asthma remediation efforts have begun in both San Joaquin and Stanislaus counties as part of our California Advancing and Innovating Medi-Cal (CalAIM) initiative rollout. The MCMC plan has engaged in ongoing efforts to improve performance on the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure. Our communities were greatly impacted directly and indirectly by COVID-19, with many members avoiding areas associated with health care during the pandemic, as well as post-pandemic, whenever possible. To reduce hospital readmissions, our transition of care team works with two of our FQHCs to create a smoother transition for members who are discharged from the hospital. We also have our enhanced care management services that are part of the CalAIM initiative rollout (launched in San Joaquin County January 2022 and Stanislaus County July 2022), which includes services for adult high utilizers of emergency departments and hospital care to help coordinate and address care needs.

Assessment of HPSJ's Self-Reported Actions

HSAG reviewed HPSJ's self-reported actions in Table E.15 and determined that HPSJ adequately addressed HSAG's recommendation from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. HPSJ indicated that barriers created by COVID-19 negatively affected members' access to needed health care services and also

HPSJ's measurement year 2020 performance measure rates. HPSJ reported implementing member- and provider-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020, including:

- Conducted member outreach via member newsletters and call campaigns.
- Conducted provider education.
- Partnered with providers to remove barriers to access to needed services.
- Advocated for improved provider data exchange.
- Facilitated appointment scheduling with providers via direct scheduling or warm transfer during outreach calls.

The strategies HPSJ implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for HPSJ" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for HPSJ

Based on the overall assessment of HPSJ's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- During the 2021 Medical and State Supported Services Audits of HPSJ, A&I identified no findings in the Access and Availability of Care and State Supported Services categories.
- The HSAG auditor determined that HPSJ followed the appropriate specifications to produce valid performance measure rates for measurement year 2021.
- HPSJ's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Cervical Cancer Screening* for Stanislaus County
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* for both reporting units
  - Both *Prenatal and Postpartum Care* measures for both reporting units
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* for both reporting units
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* for San Joaquin County

- For both the *Cervical Cancer Screening Among White Members Residing in Stanislaus County* Health Equity and *Adolescent Well-Care Visits (Ages 18 to 21)* PIPs, HPSJ met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- HPSJ submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2021 Medical Audit of HPSJ, A&I identified findings in the Utilization Management, Case Management and Coordination of care, Member's Rights, Quality Management, and Administrative and Organizational Capacity categories.
- For one of the MCAS measures, the HSAG auditor identified several critical errors with HPSJ's supporting medical record documentation. Although HPSJ did not pass medical record review validation for the one measure, the HSAG auditor was able to review the full population of cases and have HPSJ remove the cases with critical errors, thereby allowing the MCMC plan to report the remaining cases for the measure.
- Across both reporting units in measurement year 2021, HPSJ performed below the minimum performance levels for 14 of the 30 measure rates that HSAG compared to benchmarks (47 percent).

2021–22 External Quality Review Recommendations

- Address the findings from the 2021 A&I Medical Audit of HPSJ by implementing the actions recommended by A&I.
- To ensure the MCMC plan fully understands the medical record requirements, review the hybrid measure specifications early in the audit process and implement additional validations for the hybrid measures.
- For measures for which HPSJ performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, HPSJ should determine whether the member- and provider-focused interventions described in Table E.15 need to be revised or abandoned based on intervention evaluation results.

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

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

Health Plan of San Mateo

Follow-Up on Prior Year Recommendations

Table E.16 provides EQR recommendations from HPSM's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.16 to preserve the accuracy of HPSM's self-reported actions.

Table E.16—HPSM's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For measures with rates below the minimum performance levels in measurement year 2020 or for which HPSM's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	The most significant impact of the COVID-19 pandemic on HPSM's performance was for preventive care services requiring in-person contact (measurement of vitals, labs, Pap smears, mammograms, etc.) as these services were either declined or deferred to minimize the risk to the member of contracting/spreading COVID-19. As such, measures with rates below the minimum performance level in measurement year 2020 included: ♦ *Cervical Cancer Screening* ♦ *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* and *Counseling for Physical Activity—Total* The rates for the following measures declined from measurement year 2019 to measurement year 2020: ♦ *Breast Cancer Screening—Total* ♦ *Chlamydia Screening in Women*

2020–21 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* ♦ *Developmental Screening in the First Three Years of Life—Total* To address the decline in performance for these measures, HPSM added improvement in rates for the following measures to our value-based payment program: ♦ *Breast Cancer Screening—Total* ♦ *Cervical Cancer Screening* ♦ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* This program rewards our PCPs with financial incentive payments for achieving set performance benchmarks for these measures. To improve rates for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure, HPSM expanded its in-home assessment program already in place for a select population of dually enrolled Medi-Cal-Medicare members that included HbA1c testing for members with diabetes to also include HbA1c testing for members who had a diagnosis of schizophrenia or bipolar disorder. HPSM also conducted proactive member outreach through mailers, member newsletters, and health information on our member website and social media, encouraging members to go to well-care

2020–21 External Quality Review Recommendations Directed to HPSM	Self-Reported Actions Taken by HPSM during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	visits/check-ups with their PCPs, as well as staying up to date with preventive cancer screenings.

Assessment of HPSM's Self-Reported Actions

HSAG reviewed HPSM's self-reported actions in Table E.16 and determined that HPSM adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. HPSM indicated that COVID-19's impact on the MCMC plan's performance in measurement year 2020 was mainly related to preventive care services requiring in-person contact. HPSM reported implementing member- and provider-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020, including:

- Added select preventive services measures to HPSM's provider value-based payment program.
- Expanded the MCMC plan's in-home assessment program for a select population of dually enrolled Medi-Cal–Medicare members to include HbA1c testing for members diagnosed with schizophrenia or bipolar disorder.
- Conducted member outreach via mailers, member newsletters, and HPSM's member website and social media accounts.

The strategies HPSM implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for HPSM" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for HPSM

Based on the overall assessment of HPSM's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- A&I identified no findings during the 2021 State Supported Services Audit of HPSM.
- The HSAG auditor determined that HPSM followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- HPSM performed above the high performance levels for the following measures in measurement year 2021:
  - *Childhood Immunization Status—Combination 10*
  - *Chlamydia Screening in Women—Total*
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
  - *Immunizations for Adolescents—Combination 2*
  - *Prenatal and Postpartum Care—Postpartum Care*
- HPSM's performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* and *Counseling for Physical Activity—Total* measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021.
- For both the *Breast Cancer Screening Among African-American Members* Health Equity and *Adolescent Well-Care Visits (Ages 18 to 21)* PIPs, HPSM met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- HPSM submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2021 Medical Audit of HPSM, A&I identified findings in all six categories and noted repeat findings in the Quality Management category.
- HPSM performed below the minimum performance levels in measurement year 2021 for the following three of 15 measure rates that HSAG compared to benchmarks (20 percent):
  - *Cervical Cancer Screening*
  - Both *Well-Child Visits in the First 30 Months* of Life measures

2021–22 External Quality Review Recommendations

- Address the findings from the 2021 A&I Medical Audit of HPSM by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Quality Management category.
- For measures for which HPSM performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, HPSM should determine whether the member- and provider-focused interventions described in Table E.16 need to be revised or abandoned based on intervention evaluation results.

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

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

Inland Empire Health Plan

Follow-Up on Prior Year Recommendations

Table E.17 provides EQR recommendations from IEHP's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.17 to preserve the accuracy of IEHP's self-reported actions.

Table E.17—IEHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For measures with rates below the minimum performance levels in measurement year 2020 or for which IEHP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	IEHP identified the following factors which impacted measure performance: ♦ The continued impact of the COVID-19 pandemic was reflected in several preventive care measures such as *Breast Cancer Screening—Total*, *Cervical Cancer Screening*, *Childhood Immunization Status—Combination 10*, and *Chlamydia Screening in Women*. Members may have opted out of seeking preventive care services that required an in-office visit. To address access to care during the COVID-19 pandemic, IEHP expanded the use of telehealth and allowed it as an acceptable visit type when medically appropriate. The following are quality improvement strategies implemented from July 1, 2021, through June 30, 2022, to address measurement year 2020 impacted rates: ♦ IEHP's member incentive program was continued in 2021 and included the following measures: ■ *Breast Cancer Screening—Total* ■ *Cervical Cancer Screening*

2020–21 External Quality Review Recommendations Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	■ *Childhood Immunization Status—Combination 10* ■ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* Members identified as needing a service were issued letters informing them of the incentive for completion of the needed service by the specified due date. ♦ For measurement year 2021, and continuing in measurement year 2022, IEHP's Global Quality P4P program supports various measures to improve provider performance. The Global Quality P4P program includes: ■ *Breast Cancer Screening—Total* ■ *Cervical Cancer Screening* ■ *Childhood Immunization Status—Combination 10* ■ *Chlamydia Screening in Women* ■ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* ■ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* HbA1c control for members with diabetes was identified as an area of focus in 2021 and continued in 2022. Two key barriers addressed were member education to manage their diabetes and MCMC plan lab data completeness. To address member education, IEHP conducted a DHCS PDSA project that focused on the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* measure. The aim of the

2020–21 External Quality Review Recommendations Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	pilot was to increase provider referrals to health education classes for members newly diagnosed with diabetes. The pilot was unsuccessful in increasing the number of referrals to health education classes and concluded in June 2022. To address MCMC plan lab data completeness, IEHP also conducted lab data reconciliation to ensure HbA1c test results were captured from all lab vendors in the network. Asthma medication management was identified as an area of focus in 2021 and continued in 2022. Two key barriers addressed were provider education about asthma medication management best practices and awareness of provider performance. To address provider education, IEHP's pharmacy department conducted a provider education campaign with a focus on optimizing assigned members' asthma medication therapies. The campaign encouraged providers to review their members' current medication regimens and add controller medications, as clinically appropriate. To address providers' awareness of their asthma medication management performance, IEHP introduced the *Asthma Medication Ratio—Total* measure to the 2022 Global Quality P4P program for PCPs. This program offers financial incentives for improved provider performance. Postpartum visits were identified as an area of focus in 2021 and continued in 2022. The OB/GYN Quality P4P program provides an opportunity for OB/GYN providers to earn a financial reward for improving the quality of maternity care. The program includes provider incentives for postpartum visits and allows

2020–21 External Quality Review Recommendations Directed to IEHP	Self-Reported Actions Taken by IEHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	telehealth visits to qualify when medically appropriate. Contraceptive care was identified as an area of focus in 2021 and continued in 2022. A barrier identified was provider education about the availability of additional funding to support family planning services. Provider education was conducted on the availability of supplemental payments for family planning services through Proposition 56.

Assessment of IEHP's Self-Reported Actions

HSAG reviewed IEHP's self-reported actions in Table E.17 and determined that IEHP adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. IEHP indicated that COVID-19 impacted the MCMC plan's performance on several preventive care measures, likely due to members not wanting to attend in-person appointments. IEHP reported implementing member- and provider-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020, including:

- Expanded use of telehealth services.
- Continued offering member incentives.
- Continued implementing the Global Quality P4P program.
- Conducted lab reconciliation to ensure all HbA1c results were captured from all vendors.
- Conducted provider education related to medication management for members with asthma and regarding the availability of supplemental payments for family planning services.

The strategies IEHP implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for IEHP" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for IEHP

Based on the overall assessment of IEHP's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- During the 2021 Medical and State Supported Services Audits of IEHP, A&I identified no findings in the Case Management and Coordination of Care, Administrative and Organizational Capacity, and State Supported Services categories. Additionally, in response to the CAP from these audits, the MCMC plan provided documentation to DHCS regarding changes IEHP made related to policies and procedures, training, implementation, and monitoring, and oversight to address the audit findings. Upon review of IEHP's documentation, DHCS closed the CAP.
- The HSAG auditor determined that IEHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- IEHP performed above the high performance level in measurement year 2021 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measure.
- IEHP's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
  - *Prenatal and Postpartum Care—Postpartum Care*
- For both the *Controlling High Blood Pressure Among African-American Members* Health Equity and *Adolescent Well-Care Visits (Ages 18 to 21)* PIPs, IEHP met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- IEHP submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- IEHP performed below the minimum performance levels in measurement year 2021 for the following six of 15 measure rates that HSAG compared to benchmarks (40 percent):
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status—Combination 10*
  - *Immunizations for Adolescents—Combination 2*

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- Both *Well-Child Visits in the First 30 Months of Life* measures

2021–22 External Quality Review Recommendations

- For measures for which IEHP performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, IEHP should determine whether the member- and provider-focused interventions described in Table E.17 need to be revised or abandoned based on intervention evaluation results.

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

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

Kaiser NorCal

Follow-Up on Prior Year Recommendations

Table E.18 provides EQR recommendations from Kaiser NorCal's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.18 to preserve the accuracy of Kaiser NorCal's self-reported actions.

Table E.18—Kaiser NorCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For measures with rates below the minimum performance levels in measurement year 2020 or for which Kaiser NorCal's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	The pandemic had an impact on measures for which Kaiser NorCal performed below the minimum performance levels or for which there were significant differences between measurement year 2019 and measurement year 2020 due to limited access to in-person visits. Based on outcomes from measurement year 2021, these measures have already improved significantly, and the only measure with a rate below the minimum performance level was *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*, which is expected to increase due to increased well-child visits. **Children's Health Domain** ♦ *Developmental Screening in the First Three Years of Life—Total* (-67.20)—Implemented use of the CMS screening tool. The 67.20 percentage point decline from measurement year 2019 to measurement year 2020 for this measure was due to Kaiser NorCal using a screening tool in measurement year 2020 that was not included in the CMS measure

2020–21 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	specification. For measurement year 2021, the MCMC plan will use a developmental screening tool that is included in the measure specification. ♦ *Immunizations for Adolescents—Combination 2* (-3.76)—Impacted by limited in-person well-care visits due to COVID-19. ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* (-22.62)—Below the minimum performance level. Impacted by limited in-person well-care visits due to COVID-19. **Women's Health Domain** ♦ *Breast Cancer Screening—Total* (-13.18) ♦ *Cervical Cancer Screening* (-2.80) ♦ *Chlamydia Screening in Women—Ages 16–20 Years* (-10.97) ♦ *Chlamydia Screening in Women—Ages 21–24 Years* (-8.69) ♦ *Chlamydia Screening in Women—Total* (-9.80) ♦ *Contraceptive Care—All Women—LARC—Ages 21–44 Years* (-0.64) ♦ *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years* (-3.44) ♦ *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years* (-2.94) ♦ *Prenatal and Postpartum Care—Postpartum Care* (-5.86) ♦ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* (-3.17)

2020–21 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Impacted by limited in-person appointments due to COVID-19. **Behavioral Health Domain** ♦ *Screening for Depression and Follow-Up Plan—Ages 18–64 Years* (-6.50) ♦ *Screening for Depression and Follow-Up Plan—Ages 65+ Years* (-8.20) Impacted by limited in-person appointments due to COVID-19. **Acute and Chronic Disease Management Domain** ♦ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total (+8.90)* Impacted by limited in-person appointments due to COVID-19. Kaiser NorCal implemented a PDSA cycle in the COVID-19 quality improvement project, which improved measures' rates significantly in measurement year 2021. By contacting members who did not have an HbA1c result on file and asking them to go to the lab to get a measurement, Kaiser NorCal's rate for this measure improved from baseline as of April 2022. Although Kaiser NorCal is still in the middle of the pandemic, the MCMC plan is seeing members in person, and all the measures that were significantly lower in measurement year 2020 or below the minimum performance levels have improved in measurement year 2021.

2020–21 External Quality Review Recommendations Directed to Kaiser NorCal	Self-Reported Actions Taken by Kaiser NorCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Across all domains, the rates for the following two measures were below the minimum performance levels in measurement year 2020: ♦ *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* Impacted by limited in-person appointments due to COVID-19.

Assessment of Kaiser NorCal's Self-Reported Actions

HSAG reviewed Kaiser NorCal's self-reported actions in Table E.18 and determined that Kaiser NorCal adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. Kaiser NorCal attributed the MCMC plan's performance below the minimum performance levels in measurement year 2020 and significant decline in performance from measurement year 2019 to measurement year 2020 to members having limited access to in-person visits due to COVID-19 restrictions. Kaiser NorCal indicated that based on in-person visits increasing, the MCMC plan's performance improved across all measures except one in measurement year 2021. Kaiser NorCal noted that the MCMC plan implemented the following interventions:

- A developmental screening tool that is included in the *Developmental Screening in the First Three Years of Life—Total* measure specification.
- Through PDSA cycles, conducted member outreach to members with no HbA1c result on file to encourage them to go to the lab for an HbA1c test.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Kaiser NorCal

Based on the overall assessment of Kaiser NorCal's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- During the 2021 Medical and State Supported Services Audits of Kaiser NorCal, A&I identified no findings in the Quality Management and State Supported Services categories.
- The HSAG auditor determined that Kaiser NorCal followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- Kaiser NorCal performed above the high performance levels in measurement year 2021 for the following eight of 15 measure rates that HSAG compared to benchmarks (53 percent):
  - *Breast Cancer Screening—Total*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status—Combination 10*
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
  - *Controlling High Blood Pressure—Total*
  - *Immunizations for Adolescents—Combination 2*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- Kaiser NorCal's performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* measure moved from below the minimum performance level in measurement year 2020 to above the minimum performance level in measurement year 2021.
- For both the *Hypertension Control Among African-American Members Living in South Sacramento* Health Equity and *Childhood Immunizations* PIPs, Kaiser NorCal met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- Kaiser NorCal submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2021 Medical Audit of Kaiser NorCal, A&I identified findings in the Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Administrative and Organizational Capacity categories. A&I identified repeat findings in the Member's Rights category.
- Kaiser NorCal performed below the minimum performance level in measurement year 2021 for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure.

2021–22 External Quality Review Recommendations

- Address the findings from the 2021 A&I Medical Audit of Kaiser NorCal by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Member's Rights category.
- For the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure, assess the factors, which may include COVID-19, that resulted in Kaiser NorCal performing below the minimum performance level for this measure in measurement year 2021 and implement quality improvement strategies that target the identified factors.

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

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

Kaiser SoCal

Follow-Up on Prior Year Recommendations

Table E.19 provides EQR recommendations from Kaiser SoCal's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.19 to preserve the accuracy of Kaiser SoCal's self-reported actions.

Table E.19—Kaiser SoCal's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For the measure with a rate below the minimum performance level in measurement year 2020 or for measures for which Kaiser SoCal's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	**COVID-19 Impact:** 2020 was an unprecedented year marked by unique and difficult challenges of the COVID-19 public health emergency. Member discomfort with in-person visits was a barrier to accessing preventive and other health care services. Many members preferred to wait to be seen and refused face-to-face health care. Kaiser SoCal rapidly pivoted to meet the needs of our members by delivering the majority of care via telehealth options. Member preference and clinical need are considered when scheduling appointment type. In-person visits began to increase in 2021 when vaccinated members were more comfortable coming in. **Improvement Strategies:** The Kaiser Permanente (KP) care delivery model focuses on disease management, healthy lifestyle, medication therapy, and innovative outreach. The KP Health Connect electronic medical record, Proactive Office Encounter workflow, care gap alerts, and panel management tools are utilized by the health care team to proactively address each member's preventive and chronic needs before, during, and after

2020–21 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	each encounter. KP.org patient portal enrollment, mobile apps, reminders, and secure messaging support members who prefer a digital approach. Kaiser SoCal monitors monthly internal MCAS measure performance data and annual DHCS MCAS rate sheet results to track performance trends and proactively identify improved and declining measure performance. Stakeholders are informed of measure performance through published scorecards, committee reports, and individual communication. Kaiser SoCal proactively engages stakeholders to implement and/or continue initiatives to improve measure performance and maintain performance of measures performing above the high performance levels. Measure performance and identified disparities drive topic selection for formal PIPs, PDSA cycles, and QIPs. **One measure performed below the minimum performance level:** *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.* Measurement year 2020 performance was 74.80 percent (7.29 percentage points below the minimum performance level of 82.09 percent). The KP Complete Care SureNet Team launched a lab order/member outreach campaign in 2021 to ensure that this population receives an annual HbA1c lab order, notification letter, and secure message on the KP.org member portal. Performance increased by 11.71 percentage points to 86.51 percent in measurement year 2021. The measure was not held to a minimum performance level benchmark in measurement year 2021.

2020–21 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Performance declined significantly in measurement year 2020 from measurement year 2019 for 12 measures. The decrease in performance is primarily attributed to COVID-19 public health emergency-related barriers to in-person screenings. Five of the 12 measures were held to a minimum performance level benchmark in measurement year 2020, of which four performed above the high performance levels and one above the minimum performance level. All five measures performed above the high performance levels in measurement year 2021. ♦ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total*. ■ The DHCS 2021 COVID-19 QIP Child and Adolescent Health domain strategy targeted this measure. The standard ambulatory pediatric office rooming Proactive Office Encounter workflow was updated, including new 2021 Bright Futures questionnaires and validation of the Nutrition, Exercise, and Screen Time Questionnaire. Staff education was conducted, and medical office leadership provides ongoing feedback on completion rates. ♦ *Breast Cancer Screening—Total* ■ During an ambulatory encounter, a care gap alert identifies female members 50 to 74 years of age with no mammogram screening in the past 12 months. A future appointment is booked or

2020–21 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	members are provided the phone number to book an appointment. ♦ *Cervical Cancer Screening* ■ During an ambulatory encounter, a care gap alert identifies members 21 to 64 years of age due for cervical cancer screening. The screening is conducted during the visit or members are provided the phone number to book an appointment. ♦ *Chlamydia Screening in Women—Total* ■ During an ambulatory encounter, a care gap alert identifies members 16 to 24 years of age with no chlamydia screening in the past 12 months. The alert triggers the physician to order a urine chlamydia test to be collected by nursing staff during the visit. ♦ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* ■ The Diabetes Complete Care Management program uses an evidence-based, population approach to provide care to diabetic patients. This includes: ○ The Diabetes Complete Care Management and primary care partnership that entails a robust meter download and medication titration to treat operation. ○ Partnership with pharmacists on medication management and adherence. ○ Members receiving an automated outreach text or phone call to have HbA1c labs drawn.

2020–21 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	○ A care gap alert that targets members who require a diabetes health education class. Seven of the 12 measures were not held to a minimum performance level benchmark: ♦ *Chlamydia Screening in Women—Ages 16–20 Years* ♦ *Chlamydia Screening in Women—Ages 21–24 Years* ■ Refer above to the *Chlamydia Screening in Women—Total* measure held to a minimum performance level. ♦ *Contraceptive Care—All Women—LARC—Ages 21–44 Years* ♦ *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years* ■ Provider and member resources are available to guide the selection and ordering of birth control. This includes a standard appointment scheduling and office workflow, a member “Which Birth Control is Best” handout, and information for providers about contraception care during the pandemic. ♦ *Screening for Depression and Follow-Up Plan—Ages 12–17 Years* ♦ *Screening for Depression and Follow-Up Plan—Ages 18–64 Years* ■ The Kaiser SoCal ambulatory care team is proactively implementing strategies to engage medical office leadership and staff members to conduct screening and ongoing monitoring of adherence to the workflow. ■ The depression care management team partners with the primary care team and

2020–21 External Quality Review Recommendations Directed to Kaiser SoCal	Self-Reported Actions Taken by Kaiser SoCal during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	psychiatry department to ensure an effective treatment process. ■ The team is exploring implementation of a process for member completion of Patient Health Questionnaire-9 screening on the kp.org portal. ♦ *Developmental Screening in the First Three Years of Life—Total* ■ The decline from measurement year 2019 to measurement year 2020 resulted due to the change to a new developmental screening tool that met the reliability and validity requirements of the *Developmental Screening in the First Three Years of Life—Total* measure. The new *Survey of Well-being of Young Children Milestones Questionnaire* tool was implemented in Quarter 4 2021.

Assessment of Kaiser SoCal's Self-Reported Actions

HSAG reviewed Kaiser SoCal's self-reported actions in Table E.19 and determined that Kaiser SoCal adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. Kaiser SoCal pointed to the effects of COVID-19 and members being reluctant to attend in-person appointments as the reason Kaiser SoCal's performance was below the minimum performance level in measurement year 2020 for one measure and declined significantly from measurement year 2019 to measurement year 2020 for several measures. Kaiser SoCal indicated that the MCMC plan's processes are designed to address each member's health care needs before, during, and after each encounter.

For the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure, Kaiser SoCal indicated that the MCMC plan launched a member outreach campaign to ensure members with schizophrenia and bipolar disorder receive their annual HbA1c screenings. DHCS did not hold MCMC plans accountable to meet a minimum performance level for this measure for measurement year 2021; therefore, HSAG can make no assessment of whether Kaiser SoCal's quality improvement efforts may have resulted in the MCMC plan's performance moving from below the minimum performance level

in measurement year 2020 to above the minimum performance level in measurement year 2021.

For measures for which Kaiser SoCal's performance declined significantly from measurement year 2019 to measurement year 2020, the MCMC plan reported implementing member- and provider-focused interventions, including:

- As part of the MCMC plan's COVID-19 QIP, updated the standard ambulatory pediatric office rooming Proactive Office Encounter workflow and conducted staff education on the new process.
- Incorporated care gap alerts into ambulatory encounters so the providers can schedule needed screening appointments or provide the phone numbers to members to schedule their own appointments.
- Offered the Diabetes Complete Care Management program to members with diabetes.
- Member education regarding contraception options.
- Provider education regarding Kaiser SoCal's guidance related to contraceptive care.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Kaiser SoCal

Based on the overall assessment of Kaiser SoCal's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- A&I identified no findings during the 2021 State Supported Services Audit of Kaiser SoCal.
- The HSAG auditor determined that Kaiser SoCal followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- Kaiser SoCal performed above the high performance levels in measurement year 2021 for 11 of the 15 measure rates that HSAG compared to benchmarks (73 percent).
- For both the *Well-Child Visits Among Members 7 to 11 Years of Age* Health Equity and *Adolescent Well-Care Visits (Ages 12 to 21)* PIPs, Kaiser SoCal met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- Kaiser SoCal submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2021 Medical Audit of Kaiser SoCal, A&I identified findings in all six categories and noted repeat findings in the Quality Management category.

- Kaiser SoCal performed below the minimum performance level in measurement year 2021 for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure.

2021–22 External Quality Review Recommendations

- Address the findings from the 2021 A&I Medical Audit of Kaiser SoCal by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Quality Management category.
- For the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure, assess the factors, which may include COVID-19, that resulted in Kaiser SoCal performing below the minimum performance level for this measure in measurement year 2021 and implement quality improvement strategies that target the identified factors.

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

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

Kern Family Health Care

Follow-Up on Prior Year Recommendations

Table E.20 provides EQR recommendations from KHS' July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.20 to preserve the accuracy of KHS' self-reported actions.

Table E.20—KHS' Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For measures with rates below the minimum performance levels in measurement year 2020 or that declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected KHS' performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	Measures that did not meet the minimum performance levels for measurement year 2020: ♦ Both *Antidepressant Medication Management* measures ♦ Asthma Medication Ratio—*Total* ♦ *Breast Cancer Screening—Total* ♦ *Cervical Cancer Screening* ♦ *Childhood Immunization Status—Combination 10* ♦ *Chlamydia Screening in Women—Total* ♦ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* ♦ All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* Factors contributing to not meeting the minimum performance levels for these measures included two key factors. First was

2020–21 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	the increase of the minimum performance levels from the 25th percentiles to the 50th percentiles beginning in measurement year 2019. Second was the evolution of the COVID-19 pandemic. The combination of both factors created a perfect storm, if you will. The pandemic resulted in statewide stay-at-home orders. This essentially put a halt to the majority of preventive health and many chronic condition management services that would have been delivered during non-pandemic times. Initiatives were completed throughout the year addressing 19 of the MCAS measures. Actions included, but were not limited to: ♦ COVID-19 Vaccinations and Back to Care Promotion encouraging KHS members to get the COVID-19 vaccine and return to their PCP for routine preventive health services. ♦ Implemented an MCAS Committee to provide oversight and direction regarding MCAS measures and develop strategies for improving compliance with the measures. ♦ Established ongoing quarterly meetings with top-volume PCPs for MCAS measure improvement. ♦ Conducted three member engagement and rewards campaigns to close member gaps in care for specific MCAS measures. ♦ Established provider-specific MCAS trending reports. ♦ Implemented gaps-in-care visibility for KHS clinical programs, member services, and for members on the KHS member portal. ♦ Created a provider coding guide for MCAS measures.

2020–21 External Quality Review Recommendations Directed to KHS	Self-Reported Actions Taken by KHS during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ Increased access to provider EHR systems for MCAS abstraction reviews. ♦ Conducted SWOT analysis and implemented an action plan related to measures within the Children's Health domain. ♦ Conducted PDSA cycles for mobile breast cancer screenings. ♦ Conducted PDSA cycles to improve performance on the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure. ♦ Conducted a PIP to improve asthma medication compliance for members ages 5 to 21 years. ♦ Conducted a PIP to increase well-care visits for low-income children and adolescents.

Assessment of KHS' Self-Reported Actions

HSAG reviewed KHS' self-reported actions in Table E.20 and determined that KHS adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. KHS identified two factors that contributed to the MCMC plan's performance below the minimum performance levels:

- DHCS changing the minimum performance levels from the NCQA Quality Compass Medicaid HMO 25th percentiles to the NCQA Quality Compass Medicaid HMO 50th percentiles.
- Challenges resulting from the COVID-19 pandemic.

KHS described some of the member- and provider-focused initiatives that the MCMC plan implemented to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020, including:

- Promoted COVID-19 vaccines and encouraged members to return to their PCPs for routine preventive health services.

- Implemented additional monitoring and oversight processes.
- Offered member incentives.
- Created provider-specific performance measure trending reports.
- Increased access to provider EHR systems.
- Conducted a SWOT analysis and implemented an action plan targeting measures within the Children's Health domain.
- Conducted PDSA cycles to improve breast cancer screenings.

The strategies KHS implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for KHS" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for KHS

Based on the overall assessment of KHS' delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- A&I identified no findings during the 2021 State Supported Services Audit of KHS.
- The HSAG auditor determined that KHS followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- KHS performed above the high performance level in measurement year 2021 for the *Prenatal and Postpartum Care—Postpartum Care* measure.
- KHS' performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Breast Cancer Screening—Total*
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- For both the *Well-Child Visits Among Members Living in Central Bakersfield* Health Equity and *Asthma Medication Ratio* PIPs, KHS met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- KHS submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2021 Medical Audit of KHS, A&I identified findings in all six categories.
- KHS performed below the minimum performance levels in measurement year 2021 for 10 of the 15 measure rates that HSAG compared to benchmarks (67 percent).

2021–22 External Quality Review Recommendations

- Address the findings from the 2021 A&I Medical Audit of KHS by implementing the actions recommended by A&I.
- For measures for which KHS performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, KHS should determine whether the member- and provider-focused initiatives described in Table E.20 need to be revised or abandoned based on intervention evaluation results.

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

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

L.A. Care Health Plan

Follow-Up on Prior Year Recommendations

Table E.21 provides EQR recommendations from L.A. Care's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.21 to preserve the accuracy of L.A. Care's self-reported actions.

Table E.21—L.A. Care's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For all measures with rates below the minimum performance levels in measurement year 2020 or for which L.A. Care's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	♦ Continuing into measurement year 2020, COVID-19 had a major impact on all measures' performance levels. Members feared seeking care in an office setting, especially in Los Angeles, where positivity rates were high. To address overall hesitancy and encourage members to seek preventive care, L.A. Care launched the Back to Care L.A. campaign. The Back to Care L.A. campaign was in partnership with several other MCMC plans in Los Angeles County. This paid social media campaign encouraged community members to seek preventive services that were missed during the COVID-19 pandemic. The hashtag #backtocareLA and similar messaging was used across the MCMC plans, and each post tagged all participating MCMC plans. This messaging and hashtag were also used in a variety of other interventions such as social media campaigns for cancer screenings and well-child visits. ♦ COVID-19 had an especially severe negative impact on cancer screening rates. To encourage our members to get back on

2020–21 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	schedule with breast cancer screenings, L.A. Care utilized a paid social media campaign in October 2021 for Breast Cancer Awareness Month and an automated call campaign. Messaging in all interventions encouraged members to receive timely care. L.A. Care also partnered with the American Cancer Society and featured a breast cancer survivor in a social media video highlighting the importance of timely screenings. All automated call campaigns encouraged members to stay up to date on vaccinations, including the COVID-19 vaccine. ♦ The *Developmental Screening in the First Three Years of Life—Total* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measures remain in the L.A. Care Provider Opportunity Report. The Provider Opportunity Report highlights for providers which members are due for specific screenings and/or tests. This addresses the barrier for providers of not being aware of behavioral health diagnoses/prescriptions. In addition, members who fall into the denominator for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure are referred to the California Rights Meds Collaborative. This program will initiate outreach to the member to provide screening for metabolic conditions, perform targeted medication review, and reduce emergency department/inpatient admissions. Members may be facing a variety of barriers impacting their ability to seek medical care.

2020–21 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	More pressing needs such as housing and/or food access may be prioritized over their medical care. Initiating outreach to these members eliminates the barrier of them having to seek out medical care on their own. ♦ L.A. Care launched a text messaging campaign related to comprehensive diabetes control to provide education and encourage regular testing. The campaign was launched in May 2022 and will include six text messages. The L.A. Care *Diabetes* Health Equity PIP also launched during this time frame. From December 2021 through May 2022, the health education team outreached African-American members with diabetes in underserved areas to provide information via phone on diabetes resources. These members were also sent postcards and booklets with local resources to help manage their diabetes. ♦ In May 2022, L.A. Care launched a texting campaign related to controlling high blood pressure. This campaign educated members about healthy eating and urged members to see their providers regularly. From November 2021 to March 2022, L.A. Care outreached to 10 providers with a high volume of hypertensive members in Service Planning Area 5. Providers were given resources including updated CPT II codes to assist with proper coding of patient information. Providers were also given resources to access L.A. Care Web portals and phone numbers to direct questions. Lastly, 200 blood pressure cuffs were purchased and distributed to three clinics. These clinics received a member list to help identify to whom these cuffs

2020–21 External Quality Review Recommendations Directed to L.A. Care	Self-Reported Actions Taken by L.A. Care during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	should be distributed along with a tracking log for member outreach. ♦ L.A. Care continues various activities for both *Prenatal and Postpartum Care* measures. L.A. Care deployed an improved prenatal report and integrated additional prenatal identification sources. This enhanced report helps in the timely identification of pregnant members, allowing for more outreach and education opportunities about the importance of prenatal care. The health education department now promotes the Los Angeles County Department of Public Health's African American Infant and Maternal Mortality Prevention Initiative Doula Program. Promotion efforts include articles in provider and member newsletters, information posted on the L.A. Care website, and staff education. Lastly, the health education department is planning a postpartum care text messaging campaign to launch in July 2022. ♦ L.A. Care continued various activities related to the *Childhood Immunization Status—Combination 10* measure. Automated call campaigns, mailers, and a paid social media campaign promoting the importance of childhood vaccines went out during this time period. In addition, a missing vaccine report is now available on the L.A. Care provider portal. This report identifies children ages 2 and under who have missing antigens.

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

HSAG reviewed L.A. Care's self-reported actions in Table E.21 and determined that L.A. Care adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. L.A. Care attributed the MCMC plan's

performance below the minimum performance levels in 2020 and significant decline in performance from measurement year 2019 to measurement year 2020 to the effects of COVID-19 and members being hesitant to complete in-person appointments. L.A. Care reported implementing member- and provider-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020, including:

- In partnership with other MCMC plans in L.A. County, launched the Back to Care L.A. social media campaign to encourage members to seek preventive services that they missed during the COVID-19 pandemic.
- To improve cancer screening rates, launched social media and automated call campaigns.
- Distributed reports to providers that indicated members who were due for specific screenings or tests. The reports were used to initiate member outreach to help members access needed health care services and connect them to community resources.
- Launched a text messaging campaign, conducted outreach calls, and sent educational information via mail to members with diabetes to provide education about diabetes control, encourage regular testing, and inform them about diabetes resources.
- To improve prenatal and postpartum care, enhanced the MCMC plan's prenatal report and promoted the Los Angeles County Department of Public Health's African American Infant and Maternal Mortality Prevention Initiative Doula Program.
- To improve childhood immunizations, conducted automated call campaigns, mailed educational materials to members, initiated a social media campaign, and made a missing vaccine report available on the MCMC plan's provider portal.

The strategies L.A. Care implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for L.A. Care" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for L.A. Care

Based on the overall assessment of L.A. Care's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- During the 2021 Medical and State Supported Services Audits of L.A. Care, A&I identified no findings in the Quality Management and State Supported Services categories.
- The HSAG auditor determined that L.A. Care followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.

- L.A. Care performed above the high performance levels for the following measures in measurement year 2021:
  - *Chlamydia Screening in Women—Total*
  - All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures
- L.A Care's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Breast Cancer Screening—Total*
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
  - Both *Prenatal and Postpartum Care* measures
- For both the *Diabetes Among African-American Members* Health Equity and *Childhood Immunizations* PIPs, L.A. Care met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- L.A. Care submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2021 Medical Audit of L.A. Care, A&I identified findings in the Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Administrative and Organizational Capacity categories. A&I identified repeat findings in the Utilization Management and Access and Availability of Care categories.
- L.A. Care performed below the minimum performance levels in measurement year 2021 for the following three of 15 measure rates that HSAG compared to benchmarks (20 percent):
  - *Childhood Immunization Status—Combination 10*
  - Both Well-Child Visits in the First 30 Months of Life measures

2021–22 External Quality Review Recommendations

- Address the findings from the 2021 A&I Medical Audit of L.A. Care by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in the Utilization Management and Access and Availability of Care categories.
- Assess whether the strategies described in Table E.21 to improve child immunization rates need to be revised or abandoned based on L.A. Care's performance for the *Childhood Immunization Status—Combination 10* measure remaining below the minimum performance level in measurement year 2021.
- For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in L.A. Care performing below the minimum

performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors.

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

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

Molina Healthcare of California

Follow-Up on Prior Year Recommendations

Table E.22 provides EQR recommendations from Molina's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.22 to preserve the accuracy of Molina's self-reported actions.

Table E.22—Molina's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. To ensure accurate reporting in the Medi-Cal custom rate reporting templates and the patient-level detail (PLD) file, implement additional quality control processes for future performance measure reporting. Molina should use experienced staff to conduct cross-validation activities, document quality control checks, and clarify expectations with the MCMC plan's calculation vendor to ensure accurate production of the PLD file.	Molina has established a multi-step validation process to ensure accurate reporting in the Medi-Cal custom rate reporting templates and PLD file, and to ensure quality control for future performance measure reporting. Molina uses staff members experienced in PLD submissions for Medi-Cal and other lines of business to conduct cross-validation activities and document quality control checks. MCMC plan leadership communicates with Molina's calculation vendor to clarify expectations for accurate production of the PLD file.
2. For measures with rates below the minimum performance levels in measurement year 2020 or for which Molina's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers	Factors related to the ongoing COVID-19 pandemic continued to impact Molina's measurement year 2020 performance. Quality improvement strategies targeting these factors were implemented that addressed barriers to accessing preventive and other health care services. ***Breast Cancer Screening—Total*** Molina conducted a causal/barrier analysis of the measurement year 2020 rates for this measure that fell below the minimum performance level (Imperial, Sacramento, and Riverside/San Bernardino counties). The

<table>
<tr><th>2020–21 External Quality Review Recommendations Directed to Molina</th><th>Self-Reported Actions Taken by Molina during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations</th></tr>
<tr><td>to accessing preventive and other health care services.</td><td>measurement year 2020 rate for this measure also declined significantly from measurement year 2019 to measurement year 2020 in San Diego County. Findings resulted in the selection of this measure as one of the topics for Molina’s 2021–22 Women’s Health SWOT analysis project. All counties were included in this project. Barriers identified included:
♦ Members are required to visit their PCP to obtain an order for a mammogram.
♦ Member reluctance to complete in-person PCP visits during the COVID-19 pandemic.
♦ Member reluctance to travel to the mammography site during the COVID-19 pandemic.
Molina implemented the following strategies to address these barriers:
♦ Facilitated a mammography standing order process between three IPAs and their contracted mammography vendor, RadNet.
♦ Facilitated implementation of the Mammography P4P/standing order program with the vendor to increase breast cancer screening completion rates.
♦ Monitored the number of mammograms completed at RadNet sites to confirm improved access to breast cancer screening.
♦ Monitored breast cancer screening rates for the members of the three IPAs having the mammogram standing order process with RadNet.

Cervical Cancer Screening
Molina conducted a causal/barrier analysis of the measurement year 2020 rates for this measure that fell below the minimum performance level (Imperial, Sacramento, and</td></tr>
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<tr><th>2020–21 External Quality Review Recommendations Directed to Molina</th><th>Self-Reported Actions Taken by Molina during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations</th></tr>
<tr><td></td><td>Riverside/San Bernardino counties). Findings resulted in the selection of this measure as one of the topics for Molina’s 2021–22 Women’s Health SWOT analysis project. All counties were included in this project. Barriers identified included:
♦ Lack of PCP awareness of members in need of cervical cancer screenings.
♦ Member reluctance to complete in-person PCP visits during the COVID-19 pandemic.
Molina implemented the following strategies to address these barriers:
♦ Molina’s practice transformation team distributed 1,025 cervical cancer screening gaps-in-care reports to all high-volume network PCPs across all counties.
♦ Practice transformation specialists shared the following best practices with these PCPs and monitored implementation:
■ Education about the use of gaps-in-care reports for member engagement.
■ Roster reconciliation to make sure cervical cancer screening encounters were accurately submitted.
Prenatal and Postpartum Care—Timeliness of Prenatal Care
Molina conducted a causal/barrier analysis of the measurement year 2020 rates for this measure that fell below the minimum performance level (Imperial, Sacramento, and Riverside/San Bernardino counties). Findings resulted in the selection of this measure as one of the topics for Molina’s 2021–22 Women’s Health SWOT analysis project. All counties were included in this project. Molina identified one barrier:
♦ Inadequate data collection to facilitate more timely identification of pregnant members.</td></tr>
</table>

2020–21 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Molina implemented the following strategies to address this barrier: ♦ Enhanced the PNF and completed the initial PCP announcement of the form. ♦ Used the practice transformation team to train targeted PCPs and OB/GYNs to use and properly submit the PNF. ♦ Monitored submission rates of the PNFs to confirm improved compliance with the use of the form. ***Prenatal and Postpartum Care—Postpartum Care*** Molina conducted a causal/barrier analysis of the measurement year 2020 rates for this measure that fell below the minimum performance level (Imperial and Riverside/San Bernardino counties). Findings resulted in the selection of this measure as one of the topics for Molina's 2021–22 Women's Health SWOT analysis project. All counties were included in this project. Molina identified one barrier: ♦ Inadequate data collection to facilitate more timely identification of postpartum members. Molina implemented the following strategies to address this barrier: ♦ Used the PNF to identify pregnant members and promote postpartum visits prior to delivery. ♦ Used Molina's outreach team to assist members with scheduling postpartum care visits. ***Chlamydia Screening in Women—Total*** Molina conducted a causal/barrier analysis of the measurement year 2020 rate in Imperial County that fell below the minimum performance level. The measurement year

2020–21 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	2020 rate for this measure also declined significantly from measurement year 2019 to measurement year 2020 in San Diego County. Barriers identified included: ♦ Lack of PCP awareness of members in need of chlamydia screening. ♦ Imperial County clinics' refusals to complete chlamydia screenings during PCP visits. ♦ Imperial clinics' requirements for members to have an appointment with an OB/GYN for chlamydia screening. ♦ Member reluctance to complete in-person PCP or OB/GYN visits during the COVID-19 pandemic. Molina implemented the following strategy to address these barriers: ♦ Molina's practice transformation team worked with Imperial County clinics to create chlamydia screening standing orders. ***Childhood Immunization Status—Combination 10*** Molina conducted a causal/barrier analysis of the measurement year 2020 rate reductions for this measure in Sacramento and Riverside/San Bernardino counties. Findings resulted in the selection of this measure as the topic for Molina's 2020–22 *Childhood Immunization Status* PIP. Barriers identified included: ♦ Clinic provider and staff members are not educated to use the California Immunization Registry. ♦ Immunization registry inaccuracy.

2020–21 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Molina implemented the following strategies to address these barriers: ♦ Provided a monthly list to the clinic of eligible children who had their California Immunization Registry status set to “Undisclosed” so that the clinic could correct the status to “Disclosed” (open for sharing, coded “O”). ♦ Monitored the California Immunization Registry monthly for status updates. ♦ Accessed the California Immunization Registry monthly to download members’ registry data as these data became disclosed for sharing. ***Immunizations for Adolescents—Combination 2*** Molina conducted a causal/barrier analysis of the measurement year 2020 rate reductions for this measure in Sacramento and Riverside/San Bernardino counties. Findings resulted in the selection of this measure as a topic for one of Molina’s HEDIS PDSA projects for Riverside/San Bernardino counties. Barriers identified included: ♦ Providers unable to contact members to schedule immunization appointments. ♦ Parents/guardians reported that they were reluctant to bring their children into their providers’ offices for routine preventive care due to fear of COVID-19. ♦ Members non-compliant with completing all doses of the required antigens for this measure (one dose of meningococcal vaccine, one Tdap vaccine, and the complete HPV series) by their 13th birthday.

2020–21 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ HPV series requires at least two doses for compliance, with the date of service between doses being at least 146 days. Molina implemented the following strategies to address these barriers: ♦ Molina outreached to members for appointment scheduling using reports of non-compliant members assigned to select clinics in Riverside/San Bernardino counties who are aging out of the measure in 30, 60, and 90 days. ♦ Immunization appointments were scheduled directly into the clinic's EHR. ***Asthma Medication Ratio—Total*** Molina conducted a causal/barrier analysis of the measurement year 2020 rates for this measure that fell below the minimum performance level (Sacramento and Riverside/San Bernardino counties). Barriers identified included: ♦ The transition to the Medi-Cal prescription drug carve-out resulted in prescription drug data being considered supplemental data. ♦ Members/parents/guardians are unaware of the importance of using inhaled corticosteroids and other prescribed medicines correctly. ♦ Members reported reluctance to travel to the pharmacy every 30 days to pick up prescription refills, especially during the COVID-19 pandemic. ♦ Providers are unaware of members in need of prescriptions for inhaled corticosteroids. Molina implemented the following strategy to address these barriers: ♦ Molina's Medicare pharmacy team assisted with outreach calls to members with

2020–21 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	asthma to encourage them to switch to 90-day prescription fills as medically appropriate to help reduce the number of trips to the pharmacy. ***Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)*** Molina conducted a causal/barrier analysis of the measurement year 2020 rates for this measure that fell below the minimum performance level (Imperial, Sacramento, and Riverside/San Bernardino counties). Findings resulted in the selection of this measure as the topic for Molina's 2020–22 *Diabetes Control* Health Equity PIP (focusing on Sacramento County) and as a topic for one of Molina's COVID-19 QIP strategies (focusing on all counties). Barriers identified included: ♦ Member reluctance to complete in-person PCP and lab visits during the COVID-19 pandemic. ♦ Members' failure to have their HbA1c labs drawn. ♦ Members' lack of access to lab sites having convenient locations and hours of operation. ♦ Providers unaware of members in need of HbA1c labs. Molina implemented the following strategies to address these barriers: ♦ *Diabetes Control* Health Equity PIP—Completion of home HbA1c testing by eligible African-American members in Sacramento County ♦ COVID-19 QIP—Completion of home HbA1c testing by eligible members in all counties.

2020–21 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Controlling High Blood Pressure—Total Molina conducted a causal/barrier analysis of the measurement year 2020 rates for this measure that fell below the minimum performance level (Sacramento and Riverside/San Bernardino counties). Findings resulted in the selection of this measure as one of Molina's HEDIS PDSA projects for Sacramento County. Barriers identified included: ♦ Member reluctance to complete in-person PCP visits during the COVID-19 pandemic. ♦ Providers' inability to measure members' blood pressures during telehealth visits. Molina implemented the following strategy to address these barriers: ♦ Molina provided award funding for clinics to provide home blood pressure monitoring kits to non-compliant members in Sacramento County. This allowed members to monitor and report at-home blood pressure readings to their PCPs during telehealth and in-person visits. ***Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication*** Molina conducted a causal/barrier analysis of the measurement year 2020 rates for this measure that declined significantly from measurement year 2019 to measurement year 2020 in Riverside/San Bernardino counties (*Continuation and Maintenance Phase*) and in San Diego County (*Initiation Phase*). Barriers identified included: ♦ Parents/guardians reporting reluctance to bring their children into their provider's

2020–21 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	offices for routine follow-up care due to fear of COVID-19. ♦ Providers unaware of members in need of follow-up visits for their ADHD medication. Molina implemented the following strategies to address these barriers: ♦ Molina added this measure to gaps-in-care reports. ♦ *Follow-Up Care for Children Prescribed ADHD Medication* measure requirement trainings were developed and presented for providers as requested. ***Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*** Molina conducted a causal/barrier analysis of the measurement year 2020 rates that fell below the minimum performance level for this measure in Sacramento County. The measurement year 2020 rate for this measure also declined significantly from measurement year 2019 to measurement year 2020 in Riverside/San Bernardino counties. Barriers identified included: ♦ Member reluctance to complete in-person PCP and lab visits during the COVID-19 pandemic. ♦ Providers unaware of the need for diabetes screening for members with schizophrenia, schizoaffective disorder, or bipolar disorder. Molina implemented the following strategies to address these barriers: ♦ Molina added this measure to gaps-in-care reports. ♦ Molina sent specific member rosters to large clinics.

2020–21 External Quality Review Recommendations Directed to Molina	Self-Reported Actions Taken by Molina during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ Staff members of Molina's Care Connections completed in-home visits and lab draws for members identified as diabetic.

Assessment of Molina's Self-Reported Actions

HSAG reviewed Molina's self-reported actions in Table E.22 and determined that Molina adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. Molina indicated that the MCMC plan established a validation process to ensure accurate reporting in the Medi-Cal custom rate reporting templates and PLD file. Regarding performance on measures for which Molina performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020, Molina reported conducting causal/barrier analyses; based on the analyses results, Molina implemented member- and provider-focused interventions, including:

- Conducted a women's health SWOT analysis project to improve breast and cervical cancer screening rates and improve data collection processes related to prenatal and postpartum care.
- Implemented chlamydia screening standing orders in Imperial County clinics.
- Improved the MCMC plan's processes for ensuring immunization registry data are available to providers.
- Conducted member outreach and scheduled immunization appointments for members.
- Through the *Diabetes Control Among African-American Members Residing in Sacramento County* Health Equity PIP and COVID-19 QIP, facilitated at-home HbA1c testing.
- Provided funding to clinics in Sacramento County to make home blood pressure monitoring kits available to non-compliant members.
- Added select Behavioral Health domain measures to the gaps-in-care lists that were sent to providers.

The strategies Molina implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Molina" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Molina

Based on the overall assessment of Molina's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- The HSAG auditor determined that Molina followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- Molina performed above the high performance level in measurement year 2021 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measure for Sacramento County.
- Molina's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Cervical Cancer Screening* for San Diego County
  - *Chlamydia Screening in Women—Total* for Imperial County
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* for Imperial County
- Based on its performance measure results across San Diego, Imperial, Riverside/San Bernardino, and Sacramento counties, Molina performed best in San Diego County, where it performed below the minimum performance levels for two measure rates compared to 10 rates in Imperial County, 11 rates in Riverside/San Bernardino counties, and 11 rates in Sacramento County.
- For both the *Diabetes Control Among African-American Members Residing in Sacramento County* Health Equity and *Childhood Immunizations* PIPs, Molina met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- Molina submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- Across all reporting units in measurement year 2021, Molina performed below the minimum performance levels for 34 of the 60 measure rates that HSAG compared to benchmarks (57 percent).

2021–22 External Quality Review Recommendations

- For measures for which Molina performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Molina should determine whether the member- and provider-focused interventions described in Table E.22 need to be revised or abandoned based on intervention evaluation results.

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

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

Partnership HealthPlan of California

Follow-Up on Prior Year Recommendations

Table E.23 provides EQR recommendations from Partnership's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.23 to preserve the accuracy of Partnership's self-reported actions.

Table E.23—Partnership's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For measures with rates below the minimum performance levels in measurement year 2020 or for which Partnership's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	Partnership saw significant declines in most quality measures in measurement year 2020. Measures that had been performing above the minimum performance levels (i.e., *Breast Cancer Screening—Total*, *Comprehensive Diabetes Care—Hemoglobin A1c [HbA1c] Poor Control (>9.0 Percent)—Total*, *Immunizations for Adolescents—Combination 2*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*) dropped below the minimum performance levels during measurement year 2020. This decline can be attributed to several factors, most of which are a direct result of the COVID-19 public health emergency. Arguably, the largest driver of barriers for improvement has been staffing shortages throughout clinical and operational teams. Most primary care facilities faced massive staffing shortages. Several providers indicated they had to close some sites and have staff members report to other sites to have enough staff to run a single clinic. One site had physicians preparing their own exam rooms because the clinic did not have the support staff available who would normally conduct this function. Another clinic noted that

2020–21 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	it sent a mass text message to patients, advising them to use the clinic's patient portal if possible because the call center was understaffed and wait times were high. This same clinic also made a decision to stop leaving voicemails for patients when conducting outreach because when patients would return the call, they could never get through to a call center representative and it caused frustration for the patients. Staffing challenges were not limited to primary care. Imaging centers also reported issues with staffing radiology technicians. This explains why Partnership saw such a large decline in breast cancer screenings across the board. Partnership fielded reports from providers noting long wait times to schedule mammograms and declines in traditional services from the imaging centers or hospitals. As an example, one hospital resorted to only doing one member outreach attempt to schedule a mammogram, whereas before COVID-19 the hospital would make multiple attempts. This forced the health center to take on more outreach to try and connect with members for their mammograms. To try and help, Partnership established a temporary contract with a mobile mammography vendor that has had success in Partnership's service areas to try and improve access to mammograms and to supplement the limited access to brick and mortar imaging. The mobile vendor also struggled with staffing and has been unable to give Partnership viable dates for mammography clinics for providers. To address the wide range of measures that were impacted in measurement year 2020, Partnership expanded an internal effort

2020–21 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	referred to as the Quality Measure Score Improvement goal. In 2020, the goal leaders expanded the efforts from individual measure activities to broader measure domain efforts. The goal leadership established four workgroups: ♦ Pediatrics ♦ Behavioral Health ♦ Chronic Diseases ♦ Medication Management The workgroups monitored and developed interventions related to the priority measures within each domain. Since staffing in the network was challenging, Partnership took on efforts that were independent of the provider network. Outreach campaigns were conducted for several measures, including those related to diabetes, asthma, chronic obstructive pulmonary disease (COPD), and pediatric well-care visits. Partnership also conducted provider education through several campaigns. Partnership offered multiple trainings about general quality improvement through its ABCs of Quality Improvement sessions, as well as specific measure trainings through the Accelerated Learning Series. Partnership's quality improvement experts worked closely with numerous provider organizations to build capacity to use quality improvement tools and methodologies and work with the resources they have, applying these resources to specific measure interventions. Best and promising practices were evaluated and spread to additional sites or provider organizations. Partnership leveraged its pharmacists to engage members in medication-based interventions like statin therapy, and educated

2020–21 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	providers on topics like ADHD medications and COPD exacerbation. Another challenge that has been faced as a result of the public health emergency is the influx of telehealth visits. Many practices adopted systems for telehealth visits to navigate the public health emergency and continue to see patients. As a byproduct, some measures have suffered as a result. The *Controlling High Blood Pressure—Total* measure, for example, has proven challenging since providers cannot easily capture the blood pressure measurement like they would if the member were in the office. Partnership developed a device distribution program that allows members to request devices like blood pressure monitors and durable medical equipment directly from Partnership, as well as through traditional means like pharmacies. Other measures affected by telehealth visits include immunizations and well-child visits. Members need to be present to receive immunizations as well as specific parts of the physical exam. Partnership offered guidance through a webinar on best practices for conducting well-child visits during the pandemic. Another effort Partnership undertook in 2020 was adjusting its Quality Incentive Program. Partnership wanted to create a narrower focus for the provider network as it navigated the public health emergency. In 2020, Partnership reduced the number of measures from 12 to six and lowered thresholds to levels that were still attainable. Selected measures were chosen either because they were very important and should continue to be addressed, such as *Asthma Medication*

2020–21 External Quality Review Recommendations Directed to Partnership	Self-Reported Actions Taken by Partnership during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Ratio—Total, *Childhood Immunization Status—Combination 10*, *Well-Child Visits in the First 30 Months of Life*, and diabetes care measures. Measures that were ineligible for incentives were kept in the Quality Incentive Program as monitoring measures so providers could maintain visibility. In 2021, the Quality Incentive Program measure set was expanded back to the traditional number of measures, and thresholds were raised higher than the 2020 thresholds, but still below 2019 rates. Partnership believes the focus on these measures helps explain why measures such as *Childhood Immunization Status—Combination 10* and diabetes-related measures improved in 2020.

Assessment of Partnership's Self-Reported Actions

HSAG reviewed Partnership's self-reported actions in Table E.23 and determined that Partnership adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. The MCMC plan attributed the decline in rates from measurement year 2019 to measurement year 2020 and Partnership's performance being below the minimum performance levels in measurement year 2020 to a number of factors, most of which were related to COVID-19. Partnership described in detail provider challenges resulting from the COVID-19 pandemic, most of which were related to staffing shortages. To improve performance, Partnership expanded an already-existing quality improvement initiative to include performance measure domains rather than focusing efforts on individual measures. The MCMC plan established four workgroups that developed and monitored interventions related to the priority measures within each domain and focused on initiatives that were independent of Partnership's provider network. Across the performance measure domains, Partnership implemented member- and provider-focused interventions, including:

- Conducted member outreach.
- Conducted provider education.
- Identified best and promising practices and spread these practices across additional provider sites and organizations.
- Implemented a device distribution program for devices such as blood pressure monitors and durable medical equipment.

- Prioritized measures for Partnership's provider incentive program, reducing the number of measures included in the program.

The strategies Partnership implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Partnership" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for Partnership

Based on the overall assessment of Partnership's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- A&I identified no findings during the 2021 Medical and State Supported Services Audits of Partnership.
- The HSAG auditor determined that Partnership followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- Partnership performed above the high performance level in measurement year 2021 for the *Prenatal and Postpartum Care—Postpartum Care* measure for the Southeast and Southwest regions.
- Partnership's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Cervical Cancer Screening* for the Southeast Region
  - *Chlamydia Screening in Women—Total* for the Southwest Region
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* for the Northeast, Northwest, and Southeast regions
  - *Prenatal and Postpartum Care—Postpartum Care* for the Northeast Region
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in the Southwest Region
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* for the Northwest and Southwest regions
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* for the Northwest, Southeast, and Southwest regions
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* for all four reporting units

- Based on performance measure results across the Southeast, Southwest, Northeast, and Northwest regions, Partnership performed better in the Southeast and Southwest regions, where it performed below the minimum performance levels for four measure rates for each of these regions compared to 10 rates each in the Northeast and Northwest regions. Additionally, for the Southeast and Southwest regions, Partnership performed above the high performance level for one measure rate in each region.
- For both the *Breast Cancer Screening Among Members Living in Rural and Small Counties* Health Equity and *Well-Child Visits in the First 15 Months of Life* PIPs, Partnership met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- Partnership submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- Across all reporting units in measurement year 2021, Partnership performed below the minimum performance levels for 28 of the 60 measure rates that HSAG compared to benchmarks (47 percent).

2021–22 External Quality Review Recommendations

- For measures for which Partnership performed below the minimum performance levels in measurement year 2021, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. As part of this assessment, Partnership should determine whether the member- and provider-focused interventions described in Table E.23 need to be revised or abandoned based on intervention evaluation results.

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

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

San Francisco Health Plan

Follow-Up on Prior Year Recommendations

Table E.24 provides EQR recommendations from SFHP's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.24 to preserve the accuracy of SFHP's self-reported actions.

Table E.24—SFHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. Address the findings from the 2021 A&I Medical Audit by implementing the actions recommended by A&I, paying particular attention to the repeat findings in the Utilization Management and Access and Availability of Care categories.	SFHP has implemented many corrective actions over the last year to remediate the findings from the 2021 Medical Audit. For audit findings 1.3.1 and 4.1.2, SFHP has implemented a review of grievances and appeals for the Member Advisory Committee, with the first presentation to the committee occurring on June 6, 2022. The presentation to the Board of Governors will occur at the September 2022 Board meeting. For audit findings 1.3.2, 1.5.1, 2.5.3, and 2.5.4, SFHP updated the PCP Responsibilities section in the provider manual, updated the SFHP website, and added a component to the delegate audits. At DHCS' request, an additional update to the provider manual will occur in December 2022, adding the same updated information from the PCP Responsibilities section to the Behavioral Health section. In addition, the delegate Beacon also updated its provider manual to correct the deficiency. For audit finding 1.3.3, SFHP implemented a process prior to the audit in July 2020 to

2020–21 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	update the template letter that notifies members when their grievance status changes from expedited to standard and provides them with information about how to file a grievance if they disagree. For audit finding 1.5.2, SFHP moved the process from a contracting function to a credentialing function to allow more visibility and transparency to the process. In addition, the MCMC plan has been working closely with all delegates to obtain new forms. For audit findings 2.1.1 and 2.1.2, SFHP implemented a Health Risk Assessment and Health Information Form/Member Evaluation Tool workgroup. The workgroup was responsible for conducting a root cause analysis to determine the cause of the deficiency, identify a process to ensure the delivery of the assessments, and determine the appropriate method of risk stratification. The workgroup meets monthly and reviews the progress of the department responsible for the delivery of the assessments (customer service) and the department responsible for the risk stratification and case management once eligible members have been identified. For audit finding 2.1.3, SFHP maintains a very good relationship with California Children's Services, including having quarterly meetings with the leadership and clinical rounding to ensure that shared patients are reviewed and provided all benefits to which they are entitled. For audit findings 2.5.1 and 2.5.2, SFHP has been working closely with San Francisco County to renegotiate a new memorandum of understanding, which was presented to DHCS for approval in April 2022; however, the

2020–21 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	implementation is now on hold while SFHP is awaiting additional guidance from DHCS. For audit findings 3.8.1. and 3.8.2, SFHP has implemented a process in which Physician Certification Statement forms that contain missing information are forwarded to a queue for immediate remediation by a utilization management coordinator. In addition, targeted training and education was provided to providers who had previously submitted incomplete forms. For audit finding 4.1.1, SFHP drafted a delay letter and submitted it to both DHCS and the Department of Managed Health Care (DMHC) for review. DHCS approved the letter, and DMHC denied the letter. The reconciliation between the two agencies took until May 2022, when the letter was finally approved by DMHC. The delay letters have now been implemented. For audit finding 4.1.3, SFHP provided training and education to the grievance and appeal team. In addition, a more frequent auditing process was implemented. The compliance and oversight department reviews 30 grievances quarterly and 100 percent of all appeals quarterly. For audit finding 4.1.4, SFHP developed a process to ensure that grievances alleging discrimination are consistently forwarded to DHCS. A follow-up audit has validated that this process is occurring. For audit finding 4.2.1, SFHP added an organizational chart of the cultural and linguistic program to the quality improvement program document.

2020–21 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	For audit finding 5.1.2, SFHP added a quarterly potential quality issue (PQI) review, conducted by the delegated oversight nurse, to ensure that the PQI process was followed and CAPs are closed in a timely manner. For audit finding 5.3.1, SFHP added a quarterly audit to the annual internal audit workplan to pull a sample of new providers added to the roster to validate that they received training within 10 days.
2. To ensure SFHP accurately excludes enrollment spans for performance measure reporting, update its exclusion methodology to rely on the MCMC plan's HEDIS calculation engine (i.e., Cotiviti Quality Intelligence) to determine inclusion and exclusion criteria instead of during pre-processing steps.	For measurement year 2021, SFHP updated the exclusion methodology to include the start and end dates of the member's external comprehensive commercial or Medicare (Part A and B) or Part C coverage in the Cotiviti Quality Intelligence application enrollment input file. This ensured that only enrollment spans with dual coverage were excluded. This automated the logic and allowed the Cotiviti Quality Intelligence application to exclude the enrollment spans through the NCQA HEDIS Certified Measures[5] algorithms.
3. For measures with rates below the minimum performance levels in measurement year 2020 or for which SFHP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers	The impacts of COVID-19 on access, availability, and utilization have impacted the seven MCAS HEDIS measures that did not meet minimum performance levels and/or declined significantly from the previous measurement year. Following are either the decisions or identified next steps related to quality activities corresponding to each of these seven HEDIS measures ♦ *Asthma Medication Ratio—Total*: SFHP plans to include this measure in the 2023 quality improvement workplan. SFHP is currently planning activities to implement to improve performance.

[5] HEDIS Certified Measures[SM] is a service mark of the NCQA.

2020–21 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
to accessing preventive and other health care services.	♦ *Breast Cancer Screening—Total*: This measure is the topic for SFHP's current PIP, is included in the 2022 PNA action plan, and will be included in the 2023 quality improvement workplan. SFHP will implement the following activities to improve performance: ■ Provide health education materials to Black/African-American SFHP members. ■ Partner with San Francisco Women's Cancer Network to offer patient navigation services for Black/African-American members due for breast cancer screening. ♦ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*: This measure is included in the 2022 PNA action plan and will be included in the 2023 quality improvement workplan. SFHP will implement the following activities to improve performance: ■ Promote screening and care visits for members with diabetes through a member incentive gift card. ■ Enroll members with diabetes into the Medically Tailored Meals program, administered by Project Open Hand. ♦ *Contraceptive Care—All Women—LARC—Ages 21–44 Years* and *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years*: For both of these measures, although identified as statistically significant, each measure decreased by less than 2 percentage points. Additionally, for measurement year 2021, the rates for both measures increased. Since MCMC

2020–21 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	plans are not held to minimum performance levels for these measures due to them not having national benchmarks, SFHP has deprioritized these HEDIS measures in favor of improving another pharmacy utilization related measure, *Asthma Medication Ratio—Total*. ♦ *Developmental Screening in the First Three Years of Life—Total*: Although the rate for this measure decreased by 3.03 percentage points from measurement year 2019 to measurement year 2020, SFHP has chosen to prioritize the two *Well-Child Visits in the First 30 Months of Life* measures, as SFHP's measurement year 2021 HEDIS rates indicate that these measures did not meet DHCS' minimum performance levels, whereas MCMC plans are not held to meeting a minimum performance level for the *Developmental Screening in the First Three Years of Life—Total* measure due to no national benchmarks existing for this measure. SFHP will focus child health improvement efforts on the *Well-Child Visits in the First 30 Months of Life* measures. SFHP will implement the following activities to improve performance: ■ Promote well-child visits for members ages 0 to 15 months through a member incentive gift card. ■ Partner with local community-based organizations to educate members and facilitate connections to care. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total*: Although the rate for this measure decreased by 11.55 percentage points from measurement year

2020–21 External Quality Review Recommendations Directed to SFHP	Self-Reported Actions Taken by SFHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	2019 to measurement year 2020, SFHP has chosen to prioritize the *Well-Child Visits in the First 30 Months of Life* measures because SFHP's measurement year 2021 HEDIS rates indicate that the rates for the *Well-Child Visits in the First 30 Months of Life* measures do not meet DHCS' minimum performance levels, whereas the rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* measure met the minimum performance level in measurement year 2021. SFHP will focus child health improvement efforts as indicated above.
4. To ensure SFHP produces a PNA report in 2022 that meets DHCS' requirements, complete the following: a. Identify two MCMC Plan staff members who will be responsible for the content and timely submission of the PNA report. b. Ensure at least one of the two identified MCMC plan staff members attends all technical assistance sessions offered by DHCS health education consultants. c. Adhere to DHCS' MCMC plan-specific technical assistance, including feedback provided by DHCS via previous PNA rubrics. d. On a date to be determined by DHCS and MCMC plan staff, submit a draft PNA report to DHCS for review.	SFHP produced the 2022 PNA report, which met DHCS' described steps, including: a. SFHP identified Yves Gibbons, the Quality & Access senior program manager, and Etecia Burrell, the Population Health program manager, as the main staff members responsible for completing the PNA report. b. The two responsible staff members, Yves Gibbons and Etecia Burrell, attended the PNA technical assistance sessions. c. SFHP staff utilized the PNA template and the rubrics and feedback detailed in the PNA review guide and approval form to adhere to the PNA requirements. d. SFHP submitted the 2022 PNA to DHCS on the due date of June 30, 2022.

Assessment of SFHP's Self-Reported Actions

HSAG reviewed SFHP's self-reported actions in Table E.24 and determined that SFHP adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. SFHP provided details about the steps the MCMC plan has taken to address the findings from the 2021 A&I Medical Audit of SFHP, including implementing new processes, updating provider documents, and conducting trainings. SFHP also summarized how it updated the MCMC plan's exclusion methodology to ensure that SFHP accurately excludes enrollment spans for performance measure reporting.

SFHP attributed the MCMC's performance below the minimum performance levels in measurement year 2020 and significant decline in performance from measurement year 2019 to measurement year 2020 to the effects of COVID-19. SFHP described decisions the MCMC plan made as well as identified next steps related to quality improvement activities designed to improve SFHP's performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020. The following are activities SFHP has conducted or is planning to conduct:

- Include measures for which SFHP needs to improve performance in the MCMC plan's 2022 PNA action plan and 2023 quality improvement workplan.
- Provide Black/African-American members with health education materials and offer them patient navigation services to improve breast cancer screening rates for this population.
- To improve HbA1c screening rates, offer a member incentive to members with diabetes who complete their HbA1c screening and are seen for a care visit, and enroll members with diabetes into a medically tailored meals program.
- Promote well-child visits for members ages 0 to 15 months through a member incentive gift card, and partner with local community-based organizations to conduct member education and facilitate connections to care.

Finally, SFHP summarized the steps the MCMC plan took to ensure SFHP produced a PNA report in 2022 that met DHCS' requirements.

The activities SFHP implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for SFHP" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for SFHP

Based on the overall assessment of SFHP's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- During the 2022 Medical and State Supported Services Audits of SFHP, A&I identified no findings in the Access and Availability of Care, Administrative and Organizational Capacity, and State Supported Services categories.
- While the CAP for the MCMC plan's 2021 A&I Medical Audit remains open as of the production of this report, SFHP's self-reported actions as summarized in Table E.24 demonstrate that the MCMC plan has taken actions to address all findings identified by A&I.
- The HSAG auditor determined that SFHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- SFHP performed above the high performance levels for the following measures in measurement year 2021:
  - *Childhood Immunization Status—Combination 10*
  - *Chlamydia Screening in Women—Total*
  - *Controlling High Blood Pressure—Total*
  - *Immunizations for Adolescents—Combination 2*
  - Both *Prenatal and Postpartum Care* measures
- SFHP's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Breast Cancer Screening—Total*
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total*
- For both the *Breast Cancer Screening Among African-American Members* Health Equity and *Well-Child Visits in the First 15 Months of Life* PIPs, SFHP met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- SFHP submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2022 Medical Audit of SFHP, A&I identified findings in the Utilization Management, Case Management and Coordination of Care, Member's Rights, and Quality Management categories. A&I identified repeat findings in all categories except Quality Management.
- SFHP's CAP from the 2021 A&I Medical Audit remains open as of the production of this report.
- SFHP performed below the minimum performance levels in measurement year 2021 for both *Well-Child Visits in the First 30 Months of Life* measures.

2021–22 External Quality Review Recommendations

- Address the findings from the 2022 A&I Medical Audit of SFHP by implementing the actions recommended by A&I, paying particular attention to the repeat findings A&I identified in all categories except Quality Management.
- Continue to work with DHCS to fully resolve all findings from the 2021 A&I Medical Audit of SFHP.
- For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in SFHP performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors. As part of this assessment, SFHP should determine whether the interventions described in Table E.24 need to be revised or abandoned based on intervention evaluation results.

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

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

Santa Clara Family Health Plan

Follow-Up on Prior Year Recommendations

Table E.25 provides EQR recommendations from SCFHP's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.25 to preserve the accuracy of SCFHP's self-reported actions.

Table E.25—SCFHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. Continue working with DHCS to fully resolve the findings from the 2019, 2020, and 2021 Medical Audits of SCFHP.	SCFHP has been in communication with the DHCS Compliance Unit to resolve the findings from the 2019 and 2020 Medical Audits.
2. For measures with rates below the minimum performance levels in measurement year 2020 or for which SCFHP's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	The rate for the *Childhood Immunization Status—Combination* 10 measure has declined each year since 2019. The decline was mainly due to COVID-19 and is consistent with information from the California Department of Public Health regarding the impact of COVID-19 on routine vaccinations. SCFHP has continuously communicated with providers and educated members about the importance of vaccines. In addition, SCFHP emphasized the time frame of each vaccine since a catch-up dose could result in non-compliance for this measure. SCFHP also identified the flu vaccine as one of the vaccines for which members are non-compliant. In calendar year 2022, SCFHP implemented member incentives. The rate for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total* improved for measurement year 2021 due to

2020–21 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	provider education about documentation of BMI percentile versus BMI value. Providers taking height and weight measurements during in-person visits also contributed to the rate increasing post COVID-19, although some providers and clinics are still not fully operational. The rate for the *Breast Cancer Screening—Total* measure is also trending downward. SCFHP noted that there was limited appointment availability for mammogram services in county clinics where more than 50 percent of our members obtained services. SCFHP continuously discussed the situation with the delegated entity and requested that it expand appointment accessibility and availability. In addition, SCFHP partnered with providers to host a mobile mammogram clinic day. SCFHP identified an ethnic disparity and conducted a focus group to identify the root causes. In calendar year 2022, SCFHP implemented member outreach and incentives targeting the disparate group to close the disparity gap. The rate for the *Chlamydia Screening in Women—Total* measure improved and was above the minimum performance level for measurement year 2021. Clinic days were implemented, and SCFHP enhanced the care gap list to include the last chlamydia screening date and last rendering service PCP/GYN. The rate for the *Contraceptive Care—All Women—LARC—Ages 21–44 Years* measure improved in measurement year 2021. SCFHP educated members about contraceptive care during postpartum outreach calls and through member newsletters.

2020–21 External Quality Review Recommendations Directed to SCFHP	Self-Reported Actions Taken by SCFHP during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	For the *Plan All-Cause Readmissions—Observed Readmissions—Total* measure, SCFHP accessed census discharge data from various hospitals and shared the data with providers for transition of care to avoid readmissions. SCFHP also analyzed hospital readmissions data for member case management and coordination of care.

Assessment of SCFHP's Self-Reported Actions

HSAG reviewed SCFHP's self-reported actions in Table E.25 and determined that SCFHP adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. SCFHP indicated that the MCMC plan has been in contact with DHCS to resolve the findings from the Medical Audit CAPs. Additionally, SCFHP noted that the MCMC plan's measurement year 2020 performance was negatively impacted by COVID-19 and reported implementing member- and provider-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020, including:

- Conducted member and provider education regarding the importance of vaccines and the time frame in which each dose should be administered.
- Offered member incentives to members who received their flu vaccine.
- Conducted provider education about documentation of BMI percentile versus BMI value.
- Partnered with the MCMC plan's delegated entity and providers to improve access to mammogram services.
- Conducted a focus group to determine root causes of the identified ethnic disparity related to mammogram rates and implemented member outreach and incentive activities targeting the disparate group.
- Conducted member outreach and education related to contraceptive care.

The strategies SCFHP implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for SCFHP" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for SCFHP

Based on the overall assessment of SCFHP's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- In response to the CAP from the 2019 A&I Medical Audit of SCFHP, the MCMC plan provided documentation to DHCS that resulted in DHCS closing the CAP.
- While the CAP for the MCMC plan's 2020 A&I Medical Audit remains open as of the production of this report, SCFHP indicated in Table E.25 that the MCMC plan has been in communication with DHCS to resolve the findings from the 2020 Medical Audit.
- A&I identified no findings during the 2022 State Supported Services Audit of SCFHP.
- The HSAG auditor determined that SCFHP followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- SCFHP performed above the high performance levels for the following measures in measurement year 2021:
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- SCFHP's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women—Total*
- For both the *Adolescent Well-Care Visits in Network 20* Health Equity and *Lead Screening in Children* PIPs, SCFHP met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- SCFHP submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- SCFHP's CAPs from the 2020 and 2021 A&I Medical Audits remain open as of the production of this report.
- During the 2022 Medical Audit of SCFHP, A&I identified findings in all six categories and noted a repeat finding in the Access and Availability of Care category.

- SCFHP performed below the minimum performance levels in measurement year 2021 for both *Well-Child Visits in the First 30 Months of Life* measures.

2021–22 External Quality Review Recommendations

- Continue to work with DHCS to fully resolve all findings from the 2020 and 2021 A&I Medical Audits of SCFHP.
- Address the findings from the 2022 A&I Medical Audit of SCFHP by implementing the actions recommended by A&I, paying particular attention to the repeat finding A&I identified in the Access and Availability of Care category.
- For both *Well-Child Visits in the First 30 Months of Life* measures, assess the factors, which may include COVID-19, that resulted in SCFHP performing below the minimum performance levels for these measures in measurement year 2021 and implement quality improvement strategies that target the identified factors.

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

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

SCAN Health Plan

Follow-Up on Prior Year Recommendations

Table E.26 provides EQR recommendations from SCAN's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.26 to preserve the accuracy of SCAN's self-reported actions.

Table E.26—SCAN's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to SCAN	Self-Reported Actions Taken by SCAN during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. Work with DHCS to fully resolve the three findings A&I identified in the Member's Rights category during the 2021 Medical Audit. SCAN should thoroughly review all findings and implement the actions recommended by A&I.	**4.1.1 Written Member Information (Grievance Filing Time Frames)** The Grievances and Appeals Department (GAD) has implemented the following evidence of coverage (EOC) review guidelines: ♦ Upon receipt of DHCS or CMS communications (Health Plan Management System memos, APLs, etc.), a GAD auditor reviews and documents any regulatory changes in the EOC Review Guide log. ♦ In approximately Quarter 2 of each year, SCAN's marketing team releases the upcoming year's EOC drafts for review by SCAN's business units. ♦ GAD has two assigned reviewers. Reviewer #1 notes any applicable changes needed in the EOC and submits changes to the marketing team. Reviewer #2 validates the applicable changes are made. Reviewers consist of two different members of the GAD management team. ♦ Once EOC drafts have been approved by both GAD reviewers, a signed attestation is generated confirming the year's EOC review process has been successfully completed.

2020–21 External Quality Review Recommendations Directed to SCAN	Self-Reported Actions Taken by SCAN during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	4.1.2 Provider Operations Manual (Grievance Filing Time Frames) GAD has implemented the following provider operations manual (POM) review guidelines: ♦ Upon receipt of DHCS or CMS communications (Health Plan Management System memos, APLs, etc.), a GAD auditor reviews and documents any regulatory changes in the POM Review Guide log. ♦ In approximately Quarter 2 of each year, SCAN's network management team releases the upcoming year's POM drafts for review by the business units. ♦ GAD has two assigned reviewers. Reviewer #1 notes any applicable changes needed in the POM and submits changes to the network management team. Reviewer #2 validates the applicable changes are made. Reviewers consist of two different members of the GAD management team ♦ Once POM drafts have been approved by both GAD reviewers, a signed attestation is generated confirming the year's POM review process has been successfully completed. **4.1.3 Oversight of Contracted Vendors** SCAN has developed a process to support oversight and monitoring of the SCAN contracted home care vendors to ensure timely notification to SCAN in the event that they receive a member complaint/grievance. Examples of home care include homemaker services, personal care, and home-delivered meals.

2020–21 External Quality Review Recommendations Directed to SCAN	Self-Reported Actions Taken by SCAN during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	Below are the actions taken and/or in progress: ♦ Sent communication to subcontractors reminding them of the grievance process. (SCAN will then follow up with a revision to the POM.) ♦ Review and update POM guidance for publication in 2022. ♦ Develop and provide education for home care subcontractors to comply with reporting grievance requirements as defined in the POM. ♦ Develop a monitoring process to ensure subcontractor reporting is received. ♦ Develop a CAP process for non-compliant subcontractors. ♦ Conduct SCAN internal staff training (care coordination and GAD). ♦ Review quarterly GAD reporting to identify any trends and report to quarterly Network Performance Committee.

Assessment of SCAN's Self-Reported Actions

HSAG reviewed SCAN's self-reported actions in Table E.26 and determined that SCAN adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. SCAN provided details about the actions the MCMC plan took to fully resolve the findings A&I identified in the Member's Rights category during the 2021 Medical Audit of SCAN. The MCMC plan reported making changes related to:

- Written member information.
- SCAN's POM.
- Oversight of contracted vendors.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for SCAN

Based on the overall assessment of SCAN's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- In response to the CAP from the 2021 Medical Audit of SCAN, the MCMC plan provided documentation to DHCS regarding changes the MCMC plan made related to the findings A&I identified in the Member's Rights category. Upon review of SCAN's documentation, DHCS closed the CAP.
- During the 2022 Medical Audit of SCAN, A&I identified no findings in the Member's Rights, Quality Management, and Administrative and Organizational Capacity categories.
- The HSAG auditor determined that SCAN followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- SCAN performed above the high performance levels for the following measures in measurement year 2021:
  - *Breast Cancer Screening—Total*
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
  - *Controlling High Blood Pressure—Total*
- SCAN performed above the minimum performance levels in measurement year 2021 for all measure rates that HSAG compared to benchmarks.
- For both the *Diabetes Control Among Spanish-Speaking Members* Health Equity and *Breast Cancer Screening* PIPs, SCAN met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- SCAN submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- During the 2022 Medical Audit of SCAN, A&I identified findings in the Utilization Management and Access and Availability of Care categories.

2021–22 External Quality Review Recommendations

- Address the findings from the 2022 A&I Medical Audit of SCAN by implementing the actions recommended by A&I.

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

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

UnitedHealthcare Community Plan

Follow-Up on Prior Year Recommendations

Table E.27 provides EQR recommendations from UHC's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report, along with the MCMC plan's self-reported actions taken through June 30, 2022, that address the recommendations. Please note that HSAG made minimal edits to Table E.27 to preserve the accuracy of UHC's self-reported actions.

Table E.27—UHC's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2020, through June 30, 2021, MCMC Plan-Specific Evaluation Report

2020–21 External Quality Review Recommendations Directed to UHC	Self-Reported Actions Taken by UHC during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
1. For measures with rates below the minimum performance levels in measurement year 2020 or for which UHC's performance declined significantly from measurement year 2019 to measurement year 2020, assess the factors, which may include COVID-19, that affected the MCMC plan's performance on these measures and implement quality improvement strategies that target the identified factors. Strategies should address the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services.	UHC determined that for measurement year 2020, eight of the 15 rates for which DHCS held MCPs accountable to meet minimum performance levels (53 percent) were above the minimum performance levels, a slight decrease from the nine of 19 measures exceeding the minimum performance levels in 2019 (47 percent). MCAS measures falling below the minimum performance levels in measurement year 2020 included: ♦ *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total* ♦ *Asthma Medication Ratio—Total* ♦ *Breast Cancer Screening—Total* ♦ *Cervical Cancer Screening* ♦ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total* ♦ *Immunizations for Adolescents—Combination 2* ♦ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

2020–21 External Quality Review Recommendations Directed to UHC	Self-Reported Actions Taken by UHC during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	UHC observed a significant challenge to meet women's health, chronic disease, and pediatric measure requirements. UHC identified several barriers and factors impacting performance to meet the minimum performance levels for several measures, including: ♦ Access to care was limited during the height of COVID-19 due to the stay-at-home orders. Once sites resumed normal hours of operation, the public remained nervous to access care in person due to the risk of contracting COVID-19. UHC confirmed a significant decline in utilization of medical visits, especially preventive services, and monitoring of chronic conditions. This led to a decline in HEDIS performance measure rates, especially for preventive care screening. The public health emergency resulted in provider practices that were understaffed, overwhelmed, and limited in their ability to focus on member recall efforts. Strict policies on office visits, prolonged screening requirements to enter clinics, and a pivot to telehealth services resulted in fewer patients coming in for preventive health screenings and immunizations. Some clinics closed entirely due to the pandemic or moved to a "sick visit only" approach. When quality meetings resumed in June 2020, the conversations were different. Before COVID-19, discussions about barriers focused on recall efforts, correct coding for services provided, and call campaigns. During COVID-19, conversations focused on COVID-19 outbreaks among staff, expansion of telehealth visits and their impact on performance measures, and how to work with limited staff due to layoffs. The effects of this impact continued into 2021 as

2020–21 External Quality Review Recommendations Directed to UHC	Self-Reported Actions Taken by UHC during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	provider practices sought to resume quality improvement and preventive care efforts. ♦ Based on DHCS changing the minimum performance levels from the NCQA Quality Compass 25th percentiles to the 50th percentiles, UHC had challenges meeting the minimum performance levels for the MCAS measures. The update occurred in December 2019, just before the onslaught of the pandemic. ♦ Due to COVID-19, UHC deferred member engagement programs to Quarter 4 2020, as PCP availability was impacted by office closures, transition to telehealth, and PCPs being focused on addressing members' most immediate needs. ♦ Challenges to integrate member rosters: UHC remained challenged to inform the entire provider network of its *Patient Care Opportunity Report*, as most providers were not aware of how to access monthly reports to identify members with open care gaps. UHC prioritizes practices based on high-volume practices and facilitates monthly quality improvement meetings to review rates and discuss interventions. For all other practices, UHC's clinical practice consultant maintains a network directory with at least one contact person per practice and references this directory when releasing network-wide updates, such as HEDIS and quality improvement notices. It can be challenging to determine who at the clinic can best use the *Patient Care Opportunity Report* to help coordinate care for members with identified gaps in care. ♦ Providers reported a need for proper HEDIS training/education to address their patients with open care gaps. UHC worked to develop a series of web-based, self-

2020–21 External Quality Review Recommendations Directed to UHC	Self-Reported Actions Taken by UHC during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	paced courses for a set of select HEDIS women's health, chronic disease, and pediatric measures. **Actions/Interventions** UHC developed a series of interventions targeting provider engagement, data integration, practice transformation, and member engagement. ♦ Provider Engagement: A strategy for 2020–21 was adapting the HEDIS Heroes program in which providers and MCMC plan staff members are labeled as "HEDIS Heroes" who each serve a vital role in advancing outcomes (member and MCMC plan ratings). UHC's clinical practice consultant held HEDIS Heroes meetings with network PCPs to offer trainings and an educational series in specific HEDIS-related topics. These meetings served as a forum for data sharing, review of best practices, and training sessions. Topics covered included review of how to provide services during a pandemic and best practices to recall members, especially for pediatric preventive visits. ♦ Provider Engagement: UHC implemented the 2021 Community Plan Primary Care Practitioner Incentive Program to eligible PCPs. UHC rewarded providers with financial incentives for specific care gaps that were closed in 2021. The program offered a payment per care gap closed for an identified set of MCAS measures. ♦ Provider Engagement: UHC expanded the 2021 engagement strategy, continuing to maximize resources and target high-volume practices. The MCMC plan hypothesized that these practices carried

2020–21 External Quality Review Recommendations Directed to UHC	Self-Reported Actions Taken by UHC during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	enough care gaps to impact overall rates and with significant engagement, targeted offices would continue working to close existing care gaps. UHC integrated a data-driven approach to quality improvement, targeting the high-volume practices that can influence the MCMC plan's overall HEDIS rates. In all, the practices which were highly engaged closed a total of 2,038 gaps in 2020, with several practices closing more than 40 percent of all gaps in care. This logic was applied to the 2021 provider engagement programs as practices were targeted for quality improvement training and education. ♦ Data Integration: The quality team assisted with EHR access from contracted network providers. This allowed the quality solutions team to close more than 700 care gaps in medical records that were not previously closed via data obtained in routine reporting. Member Engagement: The following programs were implemented from 2021–22 to target measures such as *Breast Cancer Screening—Total*, *Cervical Cancer Screening*, *Child and Adolescent Well-Care Visits—Total*, *Childhood Immunization Status—Combination 10*, *Controlling High Blood Pressure—Total*, and *Immunizations for Adolescents—Combination 2*: ♦ IVR Calls: Conducted IVR calls to assist with HEDIS care gap measures. ♦ Live Calls: Agents called members and offered to schedule appointments for HEDIS care gaps. ♦ Preventive Letters: Members received letters to encourage them to schedule screenings and well-child visits.

2020–21 External Quality Review Recommendations Directed to UHC	Self-Reported Actions Taken by UHC during the Period of July 1, 2021–June 30, 2022, that Address the External Quality Review Recommendations
	♦ Pfizer Child Immunization Postcard: Conducted IVR calls and mailed postcards (sponsored by Pfizer) that encouraged childhood immunizations. ♦ Early and Periodic Screening, Diagnostic, and Treatment IVR Calls: Conducted IVR calls to encourage members to schedule well-care visits for children up to 20 years of age. This impacted several HEDIS measures. ♦ National Emails for Women's Health, Flu, and Annual Well Check-Up: Sent emails to members to remind them to get their annual women's screening, influenza vaccine shots, and annual check-ups. ♦ ConsejoSano Campaigns: Sent mail and emails and conducted live calls to members to remind them to schedule appointments for HEDIS care gaps. ♦ Healthy First Steps: Implemented an incentive program that offers incentives to members for completing blocks of prenatal activities. ♦ HealPros: Implemented in-home HbA1c testing, nephropathy screening, and retinopathy screening. ♦ LetsGetChecked: Mailed in-home lead and HbA1c testing kits to eligible members. ♦ Blood Pressure Monitors: Sent members with high blood pressure a blood pressure monitor. The project engaged members in self-management and encouraged them to see their PCPs. ♦ Member Gift Cards: Provider practices were given $50 gift cards for UHC members who completed services related to specific HEDIS measures.

Assessment of UHC's Self-Reported Actions

HSAG reviewed UHC's self-reported actions in Table E.27 and determined that UHC adequately addressed HSAG's recommendations from the MCMC plan's July 1, 2020, through June 30, 2021, MCMC plan-specific evaluation report. UHC identified several barriers to the MCMC plan performing above the minimum performance levels for measurement year 2020, including:

- Limited access to care as a result of the COVID-19 stay-at-home orders.
- DHCS changing the minimum performance levels from the 25th percentiles to the 50th percentiles.
- Challenges related to integrating member rosters and providers being unaware about how to access gaps-in-care reports.
- Providers' lack of knowledge of HEDIS measure requirements.

UHC reported implementing member- and provider-focused interventions to improve performance on measures for which the MCMC plan performed below the minimum performance levels in measurement year 2020 or for which the MCMC plan's performance declined significantly from measurement year 2019 to measurement year 2020, including:

- Implemented a provider incentive program.
- Targeted provider engagement strategies to high-volume providers with a high volume of members with gaps in care.
- Conducted IVR and live calls to members with gaps in care.
- Sent educational materials to members via postcards, letters, and emails.
- Offered member incentives to members who completed prenatal activities.
- Mailed in-home HbA1c testing kits and blood pressure monitors to eligible members.

The strategies UHC implemented may have contributed to the improvement HSAG noted under the Strengths heading within the "2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for UHC" portion of this appendix.

2021–22 External Quality Review Activities Strengths, Opportunities for Improvement, and Recommendations for UHC

Based on the overall assessment of UHC's delivery of quality, accessible, and timely care through the 2021–22 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the MCMC plan:

Strengths

- During the 2021 Medical and State Supported Services Audits of UHC, A&I identified no findings in the Case Management and Coordination of Care and State Supported Services categories. Additionally, in response to the CAP from these audits, the MCMC plan provided documentation to DHCS regarding changes UHC made related to policies and procedures, training, and monitoring and oversight to address the audit findings. Upon review of UHC's documentation, DHCS closed the CAP.

- The HSAG auditor determined that UHC followed the appropriate specifications to produce valid performance measure rates for measurement year 2021 and identified no issues of concern.
- UHC performed above the high performance levels for the following measures in measurement year 2021:
  - *Chlamydia Screening in Women—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- UHC's performance for the following measures moved from below the minimum performance levels in measurement year 2020 to above the minimum performance levels in measurement year 2021:
  - *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0 Percent)—Total*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- For both the *Cervical Cancer Screening* and *Child and Adolescent Well-Care Visits (Ages 3 to 21)* PIPs, UHC met all validation criteria for modules 1 through 3 and progressed to the intervention testing phase to impact the PIP SMART Aim measures.
- UHC submitted the PNA report to DHCS as required, which included information regarding the MCMC plan's 2021 and 2022 PNA action plan objectives. DHCS reviewed and approved the MCMC plan's PNA report.

Opportunities for Improvement

- UHC performed below the minimum performance levels in measurement year 2021 for the following six of 15 measure rates that HSAG compared to benchmarks (40 percent):
  - *Breast Cancer Screening—Total*
  - *Cervical Cancer Screening*
  - *Child and Adolescent Well-Care Visits—Total*
  - *Immunizations for Adolescents—Combination 2*
  - Both *Well-Child Visits in the First 30 Months of Life* measures

2021–22 External Quality Review Recommendations

UHC's contract with DHCS ended December 31, 2022; therefore, HSAG makes no recommendations to the MCMC plan since UHC will not be under contract with DHCS in July 2023 when HSAG requests summaries of how MCMC plans addressed the 2021–22 EQR recommendations. Note that while UHC's contract ends December 31, 2022, DHCS will require the MCMC plan to participate in the measurement year 2022 performance measure validation audit process. HSAG will report UHC's measurement year 2022 performance measure results in the 2022–23 MCMC EQR technical report.